

# EXHIBIT L

Exhibit L – SEALED excerpts of Plaintiffs’ Expert Witness G. Smith  
Transcript of Deposition (Sept. 22, 2020)

PLAINTIFFS’ OPPOSITION TO DEFENDANTS’ MOTION TO EXCLUDE MARKETING  
OPINIONS OF DRs. ANNA LEMBKE, KATHERINE KEYES, ANDREW KOLODNY, AND JAKKI  
MOHR

IN THE UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

\* \* \* \* \*

THE CITY OF HUNTINGTON,

Plaintiff,

vs.

CIVIL ACTION  
NO. 3:17-01362

AMERISOURCEBERGEN DRUG  
CORPORATION, et al.,  
Defendants.

---

CABELL COUNTY COMMISSION,  
Plaintiff,

vs.

CIVIL ACTION  
NO. 3:17-01665

AMERISOURCEBERGEN DRUG  
CORPORATION, et al.,  
Defendants.

\* \* \* \* \*

Videotaped and videoconference deposition  
of DR. GORDON SMITH taken by the Defendants under  
the Federal Rules of Civil Procedure in the above-  
entitled action, pursuant to notice, before Teresa  
S. Evans, a Registered Merit Reporter, all parties  
located remotely, on the 22nd day of September,  
2020.

APPEARANCES:

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ALSO PRESENT:

Adam Hager, Videographer  
Samuel Bloom, Esquire

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BY MS. WU

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BY MR. BURNETT

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1 P R O C E E D I N G S

2 VIDEO OPERATOR: Good morning. We are  
3 going on the record at 9:04 a.m. on September 22nd,  
4 2020. Please note that the microphones are  
5 sensitive and may pick up whispering, private  
6 conversations and cellular interference. Please  
7 turn off all cell phones or place them away from  
8 the microphones, as they can interfere with the  
9 deposition audio.

10 Audio and video recording will  
11 continue to take place unless all parties agree to  
12 go off the record.

13 This is Media Unit 1 of the video  
14 recorded deposition of Gordon Smith taken Counsel  
15 for the Defendant in the matter of City of  
16 Huntington and Cabell County Commission versus  
17 AmerisourceBergen Drug Corporation, et al, filed in  
18 the United States District Court for the Southern  
19 District of West Virginia, being Civil Action Nos.  
20 3:17-01362 and 3:17-01665.

21 This deposition is being conducted  
22 remotely via Zoom conferencing. My name is Adam  
23 Hager from the firm Veritext, and I'm the  
24 videographer. The court reporter is Teresa Evans



1 from the firm Veritext.

2 I'm not authorized to administer an  
3 oath; I'm not related to any party in this action;  
4 nor am I financially interested in the outcome.

5 Counsel and all present in the room  
6 and everyone attending remotely will now state  
7 their appearances and affiliations for the record.

8 If there are any objections to  
9 proceeding, please state them at the time of your  
10 appearance, beginning with the noticing attorney.

11 MS. WU: Good morning. My name is  
12 Laura Flahive Wu of Covington & Burling, and I  
13 represent McKesson Corporation.

14 MR. HOWE: My name is Sam Howe of  
15 Covington & Burling, and I also represent McKesson  
16 Corporation.

17 MS. VITALE: Good morning. This is  
18 Christina Vitale with Reed Smith, and I represent  
19 AmerisourceBergen Drug Corporation.

20 MS. SOCHACZEWSKI: Good morning,  
21 Danielle Sochaczewski for Cardinal Health.

22 MR. FRANKS: Good morning. Ray  
23 Franks, local counsel for Cardinal Health.

24 MR. BURNETT: Good morning. This is

1 David Burnett from Motley Rice for the Plaintiffs.

2 I'm joined by Anne Kearse for the Plaintiffs.

3 MR. STOUT: Jake Stout, Motley Rice,  
4 Plaintiffs.

5 MS. SHKOLNIK: Rachel Shkolnik, Napoli  
6 Shkolnik, on behalf of West Virginia MLP  
7 Plaintiffs.

8 VIDEO OPERATOR: If there are no  
9 further appearances to be noted -- I'm sorry, say  
10 that again?

11 If there are no further appearances to  
12 be noted, would the court reporter please swear the  
13 witness.

14 (The witness was sworn.)

15 G O R D O N S M I T H  
16 was called as a witness by the Defendants, and  
17 having been first duly sworn, testified as follows:

18 EXAMINATION

19 BY MS. WU:

20 Q. Good morning, Doctor.

21 A. Good morning.

22 Q. As you just heard, my name is Laura Flahive  
23 Wu. I'm with the law firm of Covington & Burling,  
24 and I represent one of the defendants in this

1 lawsuit, McKesson Corporation.

2 Can you hear me okay? I just want to  
3 make sure that the technology is working --

4 A. Yep, no, it seems to be working quite well.

5 Q. Okay. If at any point today it's difficult  
6 for you to hear or see me, please let me know so  
7 that we can pause and reset our technology.

8 MS. WU: That goes for everyone on the  
9 line. Let's work together to make sure this goes  
10 smoothly. We've been doing that well so far in  
11 other depositions.

12 Q. Doctor, thank you for being with us  
13 virtually today. We appreciate your time. To  
14 start us off, can you state your name and business  
15 address for the record?

16 A. Yes. My name is Gordon Stephen Smith, and  
17 my business address is West Virginia University  
18 School of Public Health, Medical Center Drive,  
19 Morgantown, West Virginia.

20 Q. And I'm going to ask a few questions which  
21 are about your physical location today, and that's  
22 simply to set the scene for the transcript since we  
23 are participating in this deposition virtually.

24 Where are you physically located for

1 purposes of your deposition today?

2 A. At the Hyatt in the Harbor Hotel in  
3 downtown Baltimore.

4 Q. What type of room are you in for purposes  
5 of your deposition?

6 A. I think it's the Calvert Room. On the  
7 third floor.

8 Q. Is it -- is it a private room? It's not  
9 open to the public, sir?

10 A. It's a private conference room with the  
11 doors closed.

12 Q. Thank you. Is anyone in the room with you,  
13 Doctor?

14 A. Yes. David Burnett is with me, the  
15 counsel.

16 Q. Is there anyone else present with you?

17 A. No, there's not.

18 Q. You're participating in this deposition via  
19 a computer, correct?

20 A. Correct.

21 Q. Are there any -- is there any other  
22 technology that you're using to assist you during  
23 your deposition today?

24 A. I have a camera mounted on top of my

1 computer, but that's it.

2 Q. Okay.

3 A. And a computer mounted --

4 Q. Okay. And I would just ask if you would  
5 take your cell phone and put it away from you just  
6 because that could cause sound issues as we  
7 continue today.

8 Doctor, do you have a set of hard copy  
9 deposition exhibits?

10 A. Yes, I do.

11 Q. Okay. Just want to make sure that we're  
12 all set before we get started. We're going to go  
13 over just a few ground rules for your deposition.  
14 Have you been deposed before, Doctor?

15 A. No, I haven't.

16 Q. Have you ever testified at trial before?

17 A. No, I haven't.

18 Q. Have you ever testified under oath in any  
19 other type of legal proceeding?

20 A. No.

21 Q. Have you ever served as a consulting expert  
22 in any other litigation?

23 A. Yes, probably 30 years ago in Papua, New  
24 Guinea.

1 Q. What was the nature of the litigation in  
2 which you served as a consulting expert?

3 A. It was to determine cause of death, but I  
4 can't remember the details.

5 Q. Were you serving as a consulting physician  
6 in the context of that litigation?

7 A. Yes.

8 Q. Thank you, Doctor. So I'll briefly go over  
9 some of the ground rules for the deposition today,  
10 and then we'll move more into the substance.

11 Since you haven't been deposed before,  
12 I just want to make sure that we are on the same  
13 page so this goes smoothly. You understand that  
14 you're testifying under oath today, correct,  
15 Doctor?

16 A. Correct.

17 Q. And the oath you've taken obligates you to  
18 testify truthfully as if you were in a courtroom.  
19 Do you understand that?

20 A. Yes.

21 Q. Today, your counsel, Mr. Burnett, is there  
22 with you in person, correct?

23 A. Yes.

24 Q. During the deposition, Mr. Burnett may

1 lodge certain objections to my questions. If he  
2 lodges an objection, you may answer the question  
3 absent an instruction not to answer. Do you  
4 understand that?

5 A. I do.

6 Q. Now, also you understand that Teresa Evans,  
7 the court reporter, is taking a stenographic record  
8 of this deposition. Do you understand that?

9 A. Yes, I do.

10 Q. So it's important that we try not to talk  
11 over each other. I'll do my best. It is a little  
12 more difficult in this virtual setting, so I  
13 apologize in advance if we step over each other.  
14 But we'll try our best to have one speaker at a  
15 time. Can we agree to that, Doctor?

16 A. Yes.

17 Q. Okay. Is there any reason you cannot give  
18 truthful testimony today?

19 A. No.

20 Q. Are you taking any medications or subject  
21 to any illness that may interfere with your  
22 testimony today?

23 A. No, I'm not.

24 Q. Doctor, who is your current employer?

1 A. West Virginia University.

2 Q. What is your current title?

3 A. Professor, Epidemiology.

4 Q. How long have you held that position?

5 A. Just over three years.

6 Q. Doctor, you plan to offer expert opinions  
7 in this case, correct?

8 A. Yes.

9 Q. When were you first approached by counsel  
10 about becoming an expert in this case?

11 A. Sometime in June if I remember correctly.

12 Q. And that's June of 2020, correct, Doctor?

13 A. Correct.

14 Q. Who approached you?

15 A. Anne Kearse.

16 Q. What did plaintiffs' counsel ask you to do?

17 MR. BURNETT: Let me just interject  
18 here. As you know, you can answer that question as  
19 it pertains to your assignment, but you should not  
20 otherwise disclose your conversations with counsel.

21 A. She asked me to -- about the causes of  
22 death data and the drug overdose deaths, because  
23 she knew that I'd be working in this area.

24 Q. Doctor, how would you describe the



1 assignment that plaintiffs' counsel gave you for  
2 purposes of your testimony in this case?

3 A. Was to provide a longitudinal study of the  
4 drug overdose death patterns, both in Cabell  
5 County, in the Huntington area, and in West  
6 Virginia as a whole.

7 Q. Doctor, how much are you being paid for  
8 your expert work in this case?

9 A. I'm being paid at \$500 an hour.

10 Q. Are you being paid the same amount for your  
11 testimony in this case?

12 A. Yes.

13 Q. How much have you billed to plaintiffs'  
14 counsel for your work in this case so far?

15 A. I haven't billed anything so far.

16 Q. How many hours have you worked on this case  
17 thus far?

18 A. Approximately about 55.

19 Q. And you said you haven't billed any of that  
20 time to plaintiffs?

21 A. No, I haven't.

22 Q. Do you expect to bill that time to  
23 plaintiffs?

24 A. Yes, I do.

1 Q. Do you expect to get paid for that work,  
2 Doctor?

3 A. Yes, I do.

4 Q. Do you have an agreement with plaintiffs'  
5 counsel in writing?

6 A. I have not -- at this stage, no.

7 Q. Do you have any previous work experience  
8 for plaintiffs' counsel specifically, including  
9 Motley Rice?

10 A. No, I don't.

11 Q. How about any of the other plaintiffs' law  
12 firms in this case?

13 A. So I just put -- when you're asking about a  
14 contract, I have a contract, but I have not sent it  
15 off and signed it. So I'm not sure what exactly  
16 you are meaning with that.

17 Q. Certainly. So just to clarify the record,  
18 Doctor, that's very helpful. Is it the case that  
19 you have received a draft engagement letter from  
20 counsel for the plaintiffs in this case?

21 A. What do you mean by "a draft engagement  
22 letter"?

23 Q. Have plaintiffs' counsel provided you any  
24 written agreement for your services in this case?

1           A.    Yeah, they've given me an agreement which I  
2   am supposed to sign and send off, but I haven't  
3   done that yet.

4           Q.    Certainly. So you have an agreement in  
5   place; you simply need to execute the agreement.  
6   Correct?

7           A.    That's correct.

8           Q.    Thank you, Doctor. Could you describe how  
9   you prepared for your deposition today?

10          A.    I read over my report, read over the origin  
11   of the data for the report, looked at documents  
12   that I referred to and had discussions with  
13   counsel.

14          Q.    And when you refer to "counsel," are you  
15   referring to Mr. Burnett?

16          A.    Yes.

17          Q.    Was there any other counsel for plaintiffs  
18   involved in your preparation for today?

19          A.    Yes.

20          Q.    Who else?

21          A.    Anne Kearse and Teresa -- I can't remember  
22   her last name.

23          Q.    Thank you, Doctor. Did you speak to anyone  
24   else in anticipation of your deposition today?

1           A.    No, I did not.   Except to let my wife know  
2   where I was going.

3           Q.    Fair enough.   How about anyone who works  
4   with you?   Did any members of your team assist you  
5   in preparing for your deposition today?

6           A.    No, they did not.

7           Q.    Now, you said a short while ago that you've  
8   billed about 55 hours for your work in this case.  
9   Is that right?

10          A.    Yes.

11          Q.    Did any other members of your academic or  
12   professional team assist you in preparing your work  
13   for this case?

14          A.    No, they did not.   Not -- not over and  
15   above what was available before we started this.

16          Q.    You -- all of the work product you've  
17   generated is your own work.   No other assistants  
18   provided support.   Correct?

19          A.    If you mean for the preparation of the  
20   report, yes.   But not for my publications or other  
21   things.

22          Q.    Certainly.   So for the work that you did  
23   specific to this case, you did not use any  
24   assistants to provide additional support, correct?

1           A.     That's correct.

2           Q.     Thank you, Doctor.  Now, I want to turn to  
3     talk to your report -- about your report a bit, and  
4     just to make it a little bit easier, if you can  
5     pull out -- in the documents that we sent to you,  
6     it's Document No. 3 is a copy of your expert  
7     report.

8                     And Doctor, we'll be using that  
9     document a good deal today, so you might want to  
10    keep it close at hand.

11                    SMITH DEPOSITION EXHIBIT NO. 3

12                    (Expert Report of Gordon Smith M.B.,  
13                    CH.B., (MD Equivalent Otago  
14                    University), MPH dated August 3, 2020  
15                    was marked for identification purposes  
16                    as Smith Deposition Exhibit No. 3.)

17                    MS. WU:  And for the record, we're  
18     marking as Gordon Deposition Exhibit 1 a copy of  
19     Doctor Gordon's expert report dated August 3rd,  
20     2020.

21           Q.     Doctor, do you have a copy of your expert  
22     report which is Exhibit 1 in front of you now?

23           A.     Yes, I do.  That's labeled Exhibit 3.  You  
24     told me to pick up Exhibit 3.  You said "Exhibit

1 1."

2 Q. Oh, my apologies. I have defaulted to an  
3 old way of marking exhibits.

4 MS. WU: For purposes of the record,  
5 let me clarify. We will refer to the expert report  
6 of Doctor Gordon as Deposition Exhibit 3. That is  
7 what we've been doing in this case. My apologies.

8 Q. And thank you, Doctor Gordon. There will  
9 be gaps in our exhibits, but hopefully we'll be  
10 less confused this way. So thank you, Doctor.

11 So Doctor, do you have a copy of your  
12 report which is Deposition Exhibit No. 3 in front  
13 of you now?

14 A. Yes, I do.

15 Q. Thank you, Doctor. Doctor, does your  
16 report accurately describe the work that you did in  
17 order to prepare for testimony in this case?

18 A. Yes, it does.

19 Q. The 55 hours that you have billed -- or  
20 that you have worked for plaintiffs include time  
21 that you spent reviewing data to identify the  
22 numbers of drug overdose deaths in Cabell County  
23 and West Virginia, correct?

24 A. Yes, it did.

1 Q. The 55 hours that you have spent working  
2 for plaintiffs' counsel in this case include time  
3 you spent reviewing the Vital Statistics overdose  
4 fatality data for West Virginia from 2001 onwards,  
5 correct.

6 A. Correct.

7 Q. The 55 hours that you have spent working  
8 for plaintiffs' counsel in this case include the  
9 time that you spent obtaining fatal overdose data  
10 from the Vital Statistics for Cabell County from  
11 2001 through 2018, correct?

12 A. Correct.

13 Q. And the 55 hours that you billed in your --  
14 or that you have worked for plaintiffs' counsel  
15 included time you spent reviewing data from the  
16 West Virginia Medical Examiner's Office, correct?

17 A. Correct.

18 Q. That 55 hours that you spent working on  
19 this case also includes time that you spent time  
20 meeting with counsel for plaintiffs, correct?

21 A. Correct.

22 Q. It also includes time that you spent  
23 writing an 18-page report and reviewing the 27  
24 pages of exhibits that were attached to your

1 report. Correct?

2 A. Correct.

3 Q. That is everything that you've done for  
4 purposes of your work in connection with this  
5 litigation, correct?

6 A. If you will look in my report, I also spent  
7 time to determine the drug overdoses prior to 2001  
8 when that one data source was not available and  
9 that data is included in my report.

10 Q. Thank you, Doctor. What work did you  
11 undertake in order to identify overdoses that  
12 predate 2001 in West Virginia?

13 A. This was -- talk -- much more work than was  
14 mutually anticipated because the data were not --  
15 were so readily available. And so what I undertook  
16 was to do a detailed study of the National Center  
17 for Health Statistics available data and then I had  
18 to search through multiple documents looking for  
19 historical data, which is much harder to obtain.

20 Q. Other than reviewing data in order to  
21 identify pre-2001 overdoses, is there any other  
22 category of work that I've missed in reviewing your  
23 work in connection with this case?

24 A. Did you already mention reviewing



1 background material?

2 Q. I did not mention reviewing background  
3 material.

4 A. I guess the background was the items that I  
5 cite in the re -- in the report.

6 Q. Is there anything else in addition to your  
7 review of data for pre-2001 overdoses and reviewing  
8 background materials, specifically those cited in  
9 your report, that you undertook in order to  
10 complete your work in connection with this case?

11 A. Not that I can remember.

12 Q. Thank you, Doctor. Approximately how many  
13 hours did you spend reviewing the pre-2001 data in  
14 order to generate your opinions as to the rate of  
15 overdoses prior to 2001?

16 A. I really can't remember. I would think it  
17 took probably at least a day. It was much more  
18 time consuming than I thought.

19 Q. So it took about a day in order to review  
20 data in order to identify or estimate the number of  
21 overdoses that occurred in West Virginia prior to  
22 2001. Correct?

23 A. That's correct. Maybe a day and a bit.  
24 But yes.

1 Q. Thank you. Approximately how many hours  
2 did you spend reviewing data in order to identify  
3 the number of overdoses that occurred in Cabell  
4 County and West Virginia from 2001 to 2018?

5 A. That probably took another day and a half,  
6 and between the two of them, was probably about  
7 three days, I would say.

8 Q. When you say "between the two of them," do  
9 you mean for the pre-2001 period and then the  
10 period 2001 to 2018, Doctor?

11 A. Yes. It might have even taken me -- it  
12 depends on whether -- are you talking about just  
13 reviewing the data, or are you talking about  
14 writing it up and analyzing it?

15 Q. Just reviewing the data, Doctor.

16 A. Okay. It was probably, I would say, two  
17 days.

18 Q. Okay. Doctor, about how many hours did you  
19 spend reviewing the fatal overdose data from Vital  
20 Statistics for Cabell County specifically?

21 A. I would say probably a day.

22 So do you -- by what do you mean by  
23 "reviewing"?

24 Q. Well, Doctor, could you describe the

1 process that you undertook when you worked with the  
2 data sets cited in your report?

3 A. Yes. What it involved was making sure that  
4 I had the most recent data available from the  
5 reports, and then looking at the data and then  
6 putting it together into a graph or the tables that  
7 were prepared.

8 Q. Doctor, just for use -- if I use the term  
9 "reviewing data" today, could we use that as a  
10 shorthand for the process that you've just  
11 described?

12 A. Yes.

13 Q. Okay. Thank you. That will save us a few  
14 words.

15 Doctor, approximately how many hours  
16 did you spend reviewing the database of overdose  
17 fatalities from the West Virginia Medical  
18 Examiner's Office?

19 A. I would say probably about five or six  
20 hours from the Medical Examiner's Office.

21 MR. BURNETT: Let me just interject.  
22 Counsel, you have his final report with all the  
23 data in it. I'm not sure why you need to know how  
24 many hours he spent in the process of preparing

1 each component of the report. I would suggest we  
2 just talk about the report itself.

3 MS. WU: Thank you, Counsel.

4 Q. Doctor, approximately how many hours did  
5 you spend drafting your report?

6 MR. BURNETT: And I will interject  
7 here, I am directing you not to answer questions  
8 about the drafting process, because they're not  
9 entitled to drafts and they're not entitled to know  
10 about the drafting process.

11 THE DEPONENT: Okay.

12 MS. WU: Counsel -- Counsel, it's my  
13 understanding that witnesses, expert witnesses, are  
14 to be prepared to answer questions about the hours  
15 and billings for the case. I'm not asking about  
16 the process; simply the number of hours, similar to  
17 what would be recorded in an invoice.

18 And it's my understanding that the  
19 parties reached this agreement to avoid the need to  
20 produce invoices.

21 MR. BURNETT: Right. So my  
22 understanding is that counsel have an agreement as  
23 to disclosing billing rate and a total number of  
24 hours. It's not my understanding that there's any

1 agreement on discussion of how many hours spent  
2 drafting or the drafting process.

3 So I'm directing him not to answer.  
4 You know, I'll circle up at the break and see if  
5 that's something we can disclose, but for now, I'm  
6 going to direct him not to answer.

7 MS. WU: Okay. I don't think that is  
8 worth delaying progress here. But just to be  
9 clear, Counsel, for clarity of the record, you are  
10 instructing the witness not to testify concerning  
11 the total number of hours that he spent drafting  
12 the report which is identified as Deposition  
13 Exhibit No. 3, correct?

14 MR. BURNETT: At the moment, subject  
15 to checking with other people, yes.

16 MS. WU: Okay. Thank you.

17 BY MS. WU:

18 Q. Doctor, you still have in front of you a  
19 copy of your report which is Exhibit No. 3,  
20 correct?

21 A. Correct.

22 Q. Now, if we turn to page 1 of your report,  
23 you -- it states that you are "currently involved  
24 in multiple academic projects studying drug

1 overdoses in West Virginia, including Cabell  
2 County." Do you see that?

3 A. Yes.

4 Q. Doctor, could you identify each of the  
5 academic projects that are cited here on page 1 of  
6 your report?

7 A. Okay. The -- if I can just look at what's  
8 on this report. I don't list them on the -- on  
9 this report. Let me just check here.

10 No. On page 1, I don't list -- I list  
11 my previous work before that, and I don't see any  
12 mention of the studies that I've done in West  
13 Virginia.

14 Q. I'm sorry, Doctor, could you -- could you  
15 describe for us the multiple academic projects  
16 studying drug overdoses in West Virginia that you  
17 cite?

18 A. Okay. I will look. Here we go. On page  
19 2, I first describe my detailed work studying  
20 injury mortality that I've been working in the area  
21 for many, many years. And then I state that I was  
22 recruited in 2016 to West Virginia because of my  
23 expertise in substance abuse and in injury data.

24 I was offered the endowed chair, and

1 I'm a part of a group documenting substance abuse  
2 problems in West Virginia. I've been looking at  
3 the overdose autopsy data; we've been looking at  
4 hospital data for nonfatal overdoses; and  
5 conducting drug surveys in rural parts of the  
6 state.

7 And I'm currently funded to conduct a  
8 field study of opioid problems in the eight  
9 southernmost counties of West Virginia that are  
10 directly adjacent to Cabell County and Wayne County  
11 where the City of Huntington lies.

12 In addition, my statewide studies of  
13 drug overdoses include both Cabell County and Wayne  
14 Counties.

15 Q. Thank you, Doctor. So you're looking --  
16 just for clarity in the record, you are now  
17 referencing page 2 of your report, the last  
18 paragraph on that page. Correct?

19 A. Correct.

20 Q. Okay. Let's walk through this. So if we  
21 look back to what you just said, it says, "I am  
22 part of a group documenting substance abuse  
23 documents in West Virginia, looking at information  
24 such as autopsies (for fatal overdoses), hospital

1 discharge data (for nonfatal overdoses), and  
2 conducting drug surveys in rural parts of the  
3 state."

4 Do you see that, Doctor?

5 A. On page 2?

6 Q. Yes.

7 A. Sorry if I was -- so could you just tell me  
8 -- where was -- I was looking at the other page,  
9 because there's some more detail on the other page  
10 of the studies that I've been working on.

11 Q. Certainly, Doctor. I was referencing the  
12 last paragraph on page 2 of your report, which is  
13 what you had just read a portion of into the  
14 record.

15 A. And which were you seeking clarification  
16 on?

17 Q. The -- "I am part of a group documenting  
18 substance abuse problems in West Virginia, looking  
19 at information such as autopsies (for fatal  
20 overdoses)" --

21 A. Yes.

22 Q. -- "discharge data (for nonfatal overdoses)  
23 and conducting drug surveys in rural parts of the  
24 state."



1 Do you see that, Doctor?

2 A. Yes, I do.

3 Q. What is the group that you reference in  
4 that portion of your report?

5 A. There are several groups, actually, one of  
6 which is the colleagues that I -- the co-authors on  
7 my paper that are working on the autopsy data and  
8 the medical examiner data, and then separately, the  
9 other group that I'm -- big group that I'm working  
10 with is on page 3, the SUPPORT project where we're  
11 looking at all of the different data sources on  
12 drug problems in the state, across the state as a  
13 whole, all counties, and then specifically  
14 identifying problems in individual counties.

15 Q. Doctor, what is the first group that you  
16 mentioned related to the medical examiner data?  
17 Does it have a name?

18 A. Yes, this is our drug toxicology Forensic  
19 Drug Database.

20 Q. Doctor, you mentioned the drug toxicology  
21 forensic database group and the SUPPORT program  
22 group. Are there any other academic groups  
23 included in those that are referenced in Paragraph  
24 1 on page 1 of your report?

1           A.    Not referenced in that -- not referenced  
2   here, no.

3           Q.    Doctor, are you currently a part of any  
4   other academic groups or memberships which are  
5   engaged in the study of overdoses in Cabell County  
6   or West Virginia, more broadly?

7           A.    I guess my teaching -- I have students who  
8   occasionally work on different projects. I'm not  
9   quite sure exactly what you're meaning by "groups."

10                   I have advised students that have done  
11   analyses of drug problems in West Virginia. But  
12   those are probably the two major projects.

13                   The other project is the studies in  
14   the eight -- in the counties in the southern part  
15   of the state, which was a NIDA-funded study that I  
16   am the co-PI on with Doctor Judith Feinberg.

17           Q.    Thank you, Doctor. Let's talk about the  
18   drug toxicology forensic group. That's the first  
19   one that you identified. When did that work begin?

20           A.    My colleagues started work on that in 2005  
21   as described in our articles that were published,  
22   and I started working with them as soon as I came  
23   to West Virginia.

24           Q.    And you came to West Virginia in 2016,

1 correct, Doctor?

2 A. Correct.

3 Q. Has the drug toxicology forensic group  
4 published findings since you joined the group in  
5 2016?

6 A. Yes, we have, one of which is the article  
7 that I referred to in the -- in my paper, which is  
8 the analysis of the fentanyl data. And I've been  
9 funding --

10 Q. And the --

11 A. -- the doctoral students who have been  
12 working on that, and working with us on it.

13 Q. Thank you, Doctor. Other than the fentanyl  
14 article which is referenced in your report, are  
15 there any additional findings of the drug  
16 toxicology forensic group which have been published  
17 since you joined that group in 2016?

18 A. Yes, there's a new article that's just come  
19 out that is not on my CV - because it's just come  
20 out - on looking at the relationship of  
21 polysubstance abuse deaths in the state and  
22 relating it to alcohol.

23 Q. Did you cite that article in your report?

24 A. No. As I said, it's just come out, and so

1 I didn't. In academia, we tend to only cite  
2 reports once they're published and been peer  
3 reviewed.

4 Q. Doctor, did that polysubstance abuse  
5 article contribute to the opinions that you've put  
6 forward in your report marked as Exhibit 3?

7 A. No, it didn't at all contribute to my  
8 opinion; it just reinforced it.

9 Q. Thank you, Doctor. Does the drug  
10 toxicology forensic group have any additional  
11 forthcoming findings or opinions that you expect to  
12 be published?

13 A. We're always looking at analyzing data.  
14 We're probably about to look at some of the other  
15 long-term trends in the data. I have my doctoral  
16 students be working on some projects.

17 But like any academic project, there  
18 will be things come up, and one of the things we're  
19 particularly interested in is the long-term trends,  
20 so we'll probably be doing more data on looking at  
21 the trends as the newest data comes out. And also  
22 --

23 Q. There's -- I'm sorry, Doctor. Please go  
24 ahead.

1 A. No, that's all. Thanks.

2 Q. Doctor, there's not any paper which is  
3 slated for publication now, correct?

4 A. Correct.

5 Q. Okay. How is the drug toxicology forensic  
6 group funded?

7 A. At the moment, it's been funded over the  
8 years with some funding -- you mean funded now, or  
9 in the past?

10 Q. Let's start with now. How is it funded  
11 now?

12 A. Currently, it is funded by my endowed  
13 professorship.

14 Q. How -- and what is the source of funding  
15 for your endowed professorship?

16 A. This is the Robbins Endowment Fund from the  
17 Robbins family who endowed my professorship and  
18 provides also some of my salary and also provides  
19 some research funds with which I've been able to  
20 hire the doctoral students to work with me.

21 Q. Thank you, Doctor. When did your endowed  
22 funding start to provide resources for the drug  
23 toxicology forensic group?

24 A. As soon as I started working there in 2016,

1 end of 2016.

2 Q. Doctor, do you have knowledge of the  
3 funding sources for that group prior to your  
4 engagement with it in 2016?

5 A. I don't have the exact details, but some of  
6 it came from the National Institute of Justice, and  
7 also NIH through the Clinical and Translational  
8 Research Institute and some CDC funding through the  
9 Injury Prevention Center.

10 Q. Doctor, does the drug toxicology forensics  
11 group focus specifically on Cabell County, West  
12 Virginia?

13 A. No, it does not. But it clearly identifies  
14 each county and which county the data comes from.

15 Q. Does the drug toxicology forensics group  
16 have any service component? That is, does it  
17 provide any services to communities in West  
18 Virginia other than the data it publishes?

19 A. We provide -- the analysis of the data  
20 comes from the medical examiner's office, but we  
21 provide them with data and when they want it, and  
22 when they want to do some analyses, when they're  
23 doing testimony in the state and contributing to  
24 State policy, and local government policy when

1 needed.

2 Q. Other than the evaluation and findings  
3 which you provide to the communities in West  
4 Virginia, are there any additional services the  
5 drug toxicology forensics group provides to West  
6 Virginia's communities?

7 A. Yes, we have been providing data to  
8 individual counties in the southern states so that  
9 they can understand better their drug problems and  
10 have fed it up in community meetings to the group,  
11 and they're using it as part of their planning  
12 process.

13 Q. Doctor, to the best of your knowledge, has  
14 the drug toxicology forensics group provided data  
15 or analysis to Cabell County?

16 A. I think they have provided some data to the  
17 local -- I'm not 100 percent sure. I would assume  
18 they have over time. I haven't been -- I've only  
19 been involved with it since 2016. Goes right back  
20 to 2005, and they have provided data to the local  
21 people, because this is the best compiled data of  
22 all of the -- the actual drugs found in people.

23 Q. Doctor, during your tenure working with the  
24 drug toxicology forensic group starting in 2016, to

1 your knowledge, has Cabell County requested  
2 analysis from your working group?

3 A. Not that I'm aware of.

4 Q. How about Huntington, the City of  
5 Huntington? Has it requested evaluation or  
6 information from the drug toxicology forensic  
7 group?

8 A. I'm not 100 percent sure. I don't -- I'm  
9 not -- I'm very involved in it, and I've been  
10 providing support for it, but it has a long history  
11 and there may well have been some local inquiries.  
12 I'm not -- I'm not doing it myself personally, so I  
13 don't know everything that my colleagues are doing.

14 Q. Okay. But you're not aware of any  
15 inquiries from Cabell or Huntington, correct?

16 A. Correct.

17 Q. Thank you, Doctor. So then the next  
18 program that you mentioned is the SUPPORT program,  
19 correct, Doctor?

20 A. Yes.

21 Q. And the SUPPORT program is referenced in a  
22 number of places in your report, including on page  
23 3, correct?

24 A. Correct.



1 Q. Doctor, could you describe the SUPPORT  
2 program for us?

3 A. This is funded by the Center for Medicaid  
4 Services, through the State Health Department,  
5 Department of Health and Human Services, and the  
6 Medicaid office, to provide a comprehensive plan on  
7 drug problems in West Virginia, and specifically to  
8 look at counties and county needs.

9 And we're in the process of working on  
10 it now. We don't have any report, but we have been  
11 analyzing both hospital data and the Medicaid data  
12 and we will be producing reports on individual  
13 counties, but we haven't completed that yet.

14 But the goal is --

15 Q. Doctor --

16 A. -- to be able to document the total drug  
17 problem and what the burden of drugs are in the  
18 state.

19 Q. Thank you, Doctor. When did you begin your  
20 work with the SUPPORT program?

21 A. At about the beginning of this year.

22 Q. Beginning of --

23 A. -- 2020. And probably I've been giving  
24 them some -- I've been giving them some advice and

1 consultation because of my expertise in data and  
2 the statistics and health statistics. But I wasn't  
3 funded by them specifically until the beginning of  
4 this year.

5 Q. Okay. Do you know when the SUPPORT project  
6 began its work prior to your involvement?

7 A. Yes, I understand the funding started at  
8 about October last year.

9 Q. To the best of your knowledge, is federal  
10 money provided by CMS the only source of funding to  
11 the SUPPORT project?

12 A. That's what I understand, yes. It comes  
13 from -- through -- to the state and then to us.

14 Q. Doctor, when do you expect to submit your  
15 findings or the findings of the SUPPORT project?

16 A. There's a series -- it's a sequential  
17 process, but we would expect to have a report out  
18 by the end of this year.

19 Q. Could you describe at a high level what you  
20 expect the report to include in terms of findings?

21 A. It will report drug overdose deaths, drug  
22 overdose hospitalizations, drug overdose emergency  
23 department visits. It will include other mental  
24 health problems as well. It's not just drug

1 overdoses.

2 It will include use of treatment  
3 services, basically a comprehensive look at what  
4 the -- what the current burden -- the part we're  
5 looking at is the current burden on the population,  
6 and then to be able to separate it out by county.

7 And colleagues of mine are looking at  
8 the provision of services and what services are  
9 provided and whether they meet the needs.

10 Q. Doctor, the SUPPORT project is not specific  
11 to opioids, correct?

12 A. It's -- a major component of it is  
13 substance abuse, and that includes opioids. But it  
14 also includes other related mental health  
15 conditions, behavioral health conditions.

16 Q. And to ask the same question for the drug  
17 toxicology forensic group: The work of that group  
18 is not specific to opioids, correct?

19 A. It is specific to drugs of which opioids  
20 are the major component.

21 Q. It includes other drugs like  
22 methamphetamine, for example, correct?

23 A. Correct.

24 Q. Okay. Does the SUPPORT project that we've

1     been discussing provide any services to communities  
2     in West Virginia?

3           A.     No, it does not provide direct services.  
4     It's providing planning data for the provision --  
5     to help the state provide better services.

6           Q.     Okay. Doctor, you described findings which  
7     will be published sometime in the near term by the  
8     SUPPORT project. Are any of those findings  
9     specific to Cabell County?

10          A.     Very definitely. It's specific to multiple  
11     counties. It would have Wayne, Cabell and we  
12     envisage having maps with each county with the  
13     particular services and data for that county.

14          Q.     Doctor, have you relied on any of the  
15     SUPPORT project analysis related to Cabell County  
16     in formulating your opinions in connection with  
17     this case?

18          A.     Not the data from the SUPPORT program, no.  
19     But from my own --

20          Q.     Okay.

21          A.     -- analysis.

22          Q.     Thank you, Doctor. The third, and I  
23     believe final, project that you cited is the  
24     NIDA-funded study of the eight southern counties

1 which is referenced in your report. Correct?

2 A. Correct.

3 Q. Cabell County is not one of the eight  
4 southern counties that you referenced in your  
5 report in connection with the NIDA study, correct?

6 A. That's correct.

7 Q. When did the NIDA-funded study begin?

8 A. About two years ago.

9 Q. In 2018?

10 A. Yes. It maybe started at the beginning of  
11 2017 -- end of 2017. I can't remember the exact  
12 date.

13 Q. And that -- the NIDA-funded study was, of  
14 course, funded by NIDA, correct?

15 A. Yes, National Institute of Drug Abuse.

16 Q. And did it have any additional funding  
17 sources?

18 A. No, it did not.

19 Q. Did the NIDA study have any findings which  
20 were specific to Cabell County?

21 A. No, it did not.

22 Q. And did the NIDA study provide any --  
23 include any service component for communities in  
24 West Virginia?

1           A.     Yes, it did. It provided advice and  
2     consultation and working with them on delivery and  
3     improving services. And I would also note that  
4     these counties are very much adjacent to Cabell  
5     County and have very similar drug problems.

6           Q.     What do you mean, that they have "similar  
7     drug problems?"

8           A.     The drug overdose rates are relatively  
9     comparable.

10          Q.     What's the basis for your opinion that the  
11     drug overdose rates in Cabell County and the eight  
12     southern counties are comparable?

13          A.     Because I've got the data -- I don't have  
14     it by individual county with me. It wasn't part of  
15     my report. But I looked at the data year-by-year  
16     at the rates specific by county, and they are --  
17     they are similar problems. Often Cabell County is  
18     higher. But I don't have that data in front of me.

19          Q.     Doctor, have you conducted any comparative  
20     analysis of overdose rates in Cabell as compared to  
21     other West Virginia counties in connection with  
22     this case?

23          A.     Not in conjunction with this case, no.

24          Q.     Doctor, do you intend to offer any opinions

1 as to the comparison of overdose rates or data in  
2 Cabell County as compared with other counties in  
3 West Virginia?

4 A. It's not part of my report. I'm only  
5 preparing -- comparing to the state. And I do  
6 include state data in my report.

7 Q. That's right. So in your report, Doctor,  
8 you compare the overdose rates in Cabell County to  
9 the state of West Virginia as a whole, correct?

10 A. I'm not sure whether I actually -- maybe  
11 you could identify if I do, the exact page that I  
12 do that on. But the issue is that sometimes we  
13 only have state data and sometimes we can drill  
14 down to the county level.

15 Q. So in short, your analysis is limited by  
16 the data available, correct?

17 A. All studies are limited by the data  
18 available, not specifically my study.

19 Q. Thank you. Okay. So staying with your  
20 report, which is Deposition Exhibit No. 3, I'd like  
21 to go to page 4 where you will find the heading  
22 "Summary of Opinions." Do you see that, Doctor?

23 A. Page 3, page 4. Yes, Summary of Opinions.  
24 Yes.

1 Q. Now, following this heading, Doctor, there  
2 are three paragraphs which summarize your opinions  
3 in this case. Do you see those?

4 A. Yes.

5 Q. Doctor, do these three paragraphs provide a  
6 full and accurate description of your expert  
7 opinions in this case?

8 A. Again -- yes -- yes, they do. That was  
9 based on my analysis, and that's what I wrote.

10 Q. Doctor, do you intend to offer any expert  
11 opinions today or at trial that are not identified  
12 and summarized on pages 4 and 5 of your report?

13 MR. BURNETT: And Doctor, if you need  
14 to read the paragraphs to be sure, feel free to.

15 A. The -- my report has more extensive data  
16 than are contained in those paragraphs. It refers  
17 to other articles and my interpretation of them and  
18 -- so I would say that those paragraphs on top of  
19 page 5 cannot summarize the entire report. It's to  
20 the best of my ability to be able to summarize the  
21 main points, but there's clearly other data;  
22 otherwise, there wouldn't be another X number of  
23 pages.

24 Q. Certainly, Doctor. The underlying data is



1 -- forms the basis for your opinions which are  
2 summarized here on pages 4 and 5 of your report,  
3 correct?

4 A. Correct, they're summarized.

5 Q. Doctor, are there any other opinions beyond  
6 those that are summarized on pages 4 and 5 of your  
7 report that you expect to offer in connection with  
8 this case?

9 A. Yes, if you go to the back of the report,  
10 there's a summary at the end which is a more  
11 accurate finding of the opinions. Yes, on pages  
12 18, 17. There are opinions throughout it in terms  
13 of opinions. Page 15.

14 So they're not word for word in the  
15 summary, but there are opinions throughout the  
16 report. My interpretation --

17 Q. Do you know --

18 A. -- of a particular data or particular  
19 problem that can't be summarized in a new  
20 sentences.

21 Q. Thank you, Doctor. But generally, those  
22 opinions which are cited throughout your report are  
23 summarized on pages 4 and 5 in the Summary of  
24 Opinions, correct?

1           A.     Correct.

2                     MR. BURNETT:  Objection.

3           Q.     Doctor, are there any opinions which are  
4     not reflected in your report marked as Deposition  
5     Exhibit No. 3 which you intend to present at trial  
6     in this case?

7           A.     No.  It's based on my report.

8           Q.     Now, Doctor, we've been - just for the last  
9     few minutes - talking about your Summary of  
10    Opinions.  And for the benefit of the record, could  
11    you briefly summarize the expert opinions that  
12    you've generated in connection with this case?

13          A.     Yep.  Then I will go back and look at my --

14                     So the Summary of Opinions are "that  
15    between 2001 and 2018 at least 1151 people died of  
16    a drug overdose in Cabell County" based on the data  
17    that I had, "and 1,002" or "(87.1%) fatally  
18    overdosed on prescription or illicit opioids in the  
19    County."

20                     The rates increased sharply over this  
21    period of time from a low of 16.6 per 100,000 in  
22    2001 to a high of 2013, .9 per 100,000 in 2017, and  
23    the "fatal overdoses due to prescription opioids  
24    such as" OxyContin "and hydrocodone significantly

1 exceeded the rate of fatal overdoses due to illicit  
2 opioids, as described more further in the Report."

3 And I "further found that for West  
4 Virginia the drug poisoning rates, which are mostly  
5 due to drugs, had very low rates" -- actually,  
6 these -- had very low rates "from 1979" to "2000  
7 and began to increase dramatically from" 2000 "on  
8 when they exceeded the rate for the US as a whole."

9 I would like to point out, there is an  
10 error in my report that I picked up. This -- where  
11 I say, "I have further found that for West  
12 Virginia, the drug poisoning rates," that is  
13 actually the "accidental poisoning rates" and I  
14 later discuss the comments on that.

15 Q. Okay.

16 A. So that should be "accidental poisoning  
17 rates" which I explain very fully on in that  
18 section of the report.

19 And there's actually one tiny little  
20 typo also in the -- one, two -- third page of the  
21 third paragraph. Instead of "case," it should be  
22 "cases."

23 Q. Fair enough, Doctor.

24 A. And the only --

1 Q. I'm sorry, Doctor. I didn't mean to step  
2 over you. You just described that you wanted to  
3 amend your report on page 5, the second full  
4 paragraph, to reference "accidental drug poisoning  
5 rates" rather than "drug poisoning rates." Is that  
6 correct?

7 A. Yeah, it's just "accidental" -- remove  
8 "drug" and put "accidental."

9 Q. Okay. Doctor, what is the difference  
10 between an accidental poisoning rate and a drug  
11 poisoning rate?

12 A. In the accidental poisoning -- the drug  
13 poisoning rates are part of the drug -- the drug  
14 poisonings are part of the accidental poisonings,  
15 and as discussed and as shown in my graph which is  
16 on page 15, we could only get the data going back  
17 for these older periods of time for accidental  
18 poisonings that includes all of the drug  
19 poisonings.

20 And if you go back to page 14, there's  
21 a good article referred to by a former student of  
22 mine which shows the relation -- clear relationship  
23 of poisonings and drug poisonings as part of that.

24 Q. Thank you, Doctor. Doctor, I'm going to

1 ask you to take out another document which is  
2 Document No. 4.

3 MS. WU: And for the record, I'd like  
4 to mark as Smith Deposition Exhibit No. 4, Appendix  
5 B to Doctor Smith's report, which is a list of  
6 materials considered.

7 SMITH DEPOSITION EXHIBIT NO. 4

8 (Appendix B, List of Materials  
9 Considered for Expert Report of Gordon  
10 Smith, M.B., CH.B. (MD Equivalent  
11 Otago University), MPH was marked for  
12 identification purposes as Smith  
13 Deposition Exhibit No. 4.)

14 Q. Doctor, do you have Exhibit 4 in front of  
15 you now?

16 A. Yes, I do.

17 Q. Do you recognize this document?

18 A. Yes, I do.

19 Q. And it's a list of materials you considered  
20 in preparing your report which is Deposition  
21 Exhibit No. 3, correct?

22 A. Correct.

23 Q. The List of Materials Considered identifies  
24 all documents referenced in your expert witness

1 report, correct?

2 A. Correct. There's footnotes on each page.

3 Q. Okay. Is this list of materials considered  
4 accurate?

5 A. Yes, it is.

6 Q. So you did not consider any materials other  
7 than those cited in your report, correct?

8 A. Not in the preparation of my report, no.

9 Q. Doctor, have your opinions changed since  
10 you submitted your report on August 3rd?

11 A. No.

12 Q. Have you acquired any additional  
13 information since that time?

14 A. What do you mean by "additional  
15 information"?

16 Q. Has any new data or analysis come to your  
17 attention which has changed the opinions that you  
18 intend to offer in this case?

19 A. Certainly has not changed it. There's  
20 always new data coming in. But no, nothing has  
21 changed my opinion.

22 MR. BURNETT: Objection.

23 Q. Is there any new data on which you intend  
24 to rely in order to offer testimony in this case?

1 MR. BURNETT: Ms. Wu, sorry to  
2 interrupt. My computer's about to die. We can  
3 keep going --

4 MS. WU: Oh, okay.

5 MR. BURNETT: -- but I'll just need 30  
6 seconds to plug it in using this charger over here.  
7 Hold on.

8 MS. WU: Sure. Counsel, did you say  
9 to keep going? I don't want to --

10 MR. BURNETT: We don't have to go off  
11 the record. Just give me 20 more seconds.

12 MS. WU: Sure, certainly. Yea. No  
13 rush.

14 MR. BURNETT: Okay, I'm good.

15 MS. WU: Okay, wonderful.

16 BY MS. WU:

17 Q. Doctor, are there any new sources of  
18 information or data on which you intend to rely in  
19 order to offer opinions and testimony in this case?

20 A. No, there's not.

21 Q. Thank you. So Doctor, I'd like to go back  
22 to your report, which is Deposition Exhibit 3, and  
23 look back at page 5 in the Summary of Opinions.  
24 And I'd like to call your attention to the first

1 paragraph on the top of page 5 beginning "I have  
2 found."

3 This is the paragraph which you read  
4 into the record a short while ago. Correct?

5 A. Correct.

6 Q. And I'd like to march through the opinions  
7 summarized in this paragraph on page 5. Doctor,  
8 the sources of data you identified, what was the  
9 source of data for the statistics summarized here?

10 A. This is --

11 Q. -- in the first paragraph on page 5?

12 A. This is the data from the Vital Statistics  
13 data.

14 Q. Is there anything beyond the Vital  
15 Statistics data that you used in order to generate  
16 the analysis which is summarized in the first  
17 paragraph on page 5?

18 A. Yes, there are -- there are the Vital  
19 Statistics data that comes from this database from  
20 2000 onward, so it has very detailed data by  
21 county.

22 But then the last of those -- the  
23 second paragraph, that was not using the same  
24 database; that was using data that is being given



1 to the -- by the National Center for Health  
2 Statistics because of the problem of being able to  
3 go back and get the archival data to be able to  
4 demonstrate that the poisoning rates of which drug  
5 poisonings are a part are very low until that  
6 period of time.

7 Q. Okay. So Doctor, just to clarify, the  
8 pre-2001 accidental poisoning rate data that you're  
9 referencing is summarized in the second paragraph  
10 on page 5, correct?

11 A. That second paragraph -- yes. That's the  
12 summarize --

13 Q. Okay.

14 A. -- summary -- summarizing the graph that is  
15 produced on page 15.

16 Q. Okay. So Doctor, just to make sure that  
17 we're level set in terms of our terminology before  
18 we march ahead today, could you tell us what you  
19 mean when you use the term "drug overdose?"

20 A. Okay. It's probably easier if I start off  
21 with accidental -- accidental poisonings are all  
22 poisonings that are not -- that are not accidents  
23 -- in other words, someone tried to poison someone  
24 as a homicide or someone took the poisoning as a

1 suicide.

2 And that's -- that's accidental  
3 poisonings.

4 And then the vast bulk of those are  
5 due to a drug. And by that, I mean a drug being a  
6 legal drug or a illegal drug that's considered a  
7 standard terminology as to what a drug is.

8 And then separately to that, we then  
9 break it down to an opioid-related drug, which the  
10 vast bulk of them are opioid -- involve opioids.

11 Q. So doctor, I'm -- before we march -- we  
12 march further into your opinions, let's stay on  
13 drug overdoses just for clarity.

14 A. Yeah.

15 Q. When you refer to "drug overdoses" in the  
16 context of your report, you always mean drug  
17 overdoses to mean accidental poisonings. Correct?

18 A. Yes, accidental drug overdoses.

19 Q. Okay. Thank you. Now, Doctor, you just  
20 referenced opioids, and again, I just want to level  
21 set in our terminology. When you use the phrase  
22 "prescription opioids" in the context of your  
23 opinions in this case, what do you mean?

24 A. By "prescription drugs," I am meaning drugs

1 that can be obtained from prescription and the  
2 molecules -- the drug molecules -- the drug is a  
3 manufactured -- initially as a prescription drug.  
4 And it's a broad class of drugs. And when we're  
5 looking at all of the toxicology, it's basically  
6 that drug class.

7 Q. And when you refer to the class of  
8 prescription opioids, you're referring to drugs  
9 which have been approved by the FDA for sale in the  
10 United States. Correct?

11 A. Correct.

12 Q. Also in your report, you used the term or  
13 phrase "illicit opioids." Could you just clarify  
14 for us what you mean when you use the phrase  
15 "illicit opioids".

16 A. I refer to -- and I'll go back -- refer to  
17 -- I think I put it as a footnote somewhere.

18 -- that essentially, these are drugs  
19 that are on the DEA schedule, not considered to be  
20 prescription drugs, prescribable drugs, in the  
21 U.S., and as a result, they are declared to be  
22 illicit drugs.

23 So it's based on the DEA  
24 classification, Schedule I drugs: Substance or

1 chemicals -- this is on page 8, footnote.

2 "Schedule I drugs, substance or chemicals are  
3 defined as drugs" not "currently accepted medical  
4 use and a high potential for abuse. Some examples"  
5 are heroin, LSD, marijuana, ecstasy, peyote.

6 So that's what I consider to be  
7 illicit drugs.

8 Q. Illicit drugs are drugs that are not  
9 approved by the FDA for medical use in the United  
10 States. Correct?

11 A. Correct.

12 Q. Now, I'd like to turn back to page 5 of  
13 your report, again in your Summary of Opinions, and  
14 in the first paragraph, you say - near the end of  
15 it - that "overdoses" from "prescription opioids"  
16 "significantly exceeded the rate of fatal overdoses  
17 due to illicit opioids."

18 Do you see that, Doctor?

19 A. Yes. During that -- years up until 2011,  
20 yes.

21 Q. Doctor, can you quantify the rate at which  
22 the overdoses associated with prescription opioids  
23 exceeded those associated with illicit opioids?

24 A. That is contained in my report. If you go

1 back to the graph on page 11 of my report, you can  
2 see that heroin was the illicit drug, and  
3 prescription opioids, quite obviously from looking  
4 at -- I don't have the ratio. I could do that at  
5 another time, if needed.

6 But it's clearly -- visually, you can  
7 see that the opioid deaths --

8 And I would add that these are the  
9 drugs that were found. And up until 2011, they  
10 just weren't finding much heroin in the people that  
11 died of an overdose in West Virginia.

12 Q. Doctor, we're going to talk much more about  
13 these figures, but just for clarity in the context  
14 of this portion of the transcript, the -- what is  
15 the source of data which is used to generate Figure  
16 1 on page 11 that you just referenced?

17 A. Okay. I'll go back -- it's a sequential  
18 process. Essentially, the -- all injury deaths,  
19 all overdoses - which are included in injuries -  
20 which are accidental deaths, suicides and  
21 homicides, are reported to the medical examiner.  
22 They then do an examination of the case; they  
23 decide if it needs an autopsy.

24 And in most of -- and in almost all of

1 the drug overdose deaths, they end up doing an  
2 autopsy. They then test the blood. They then  
3 determine which of the drugs that they found were  
4 causally related, contributed to the death - is the  
5 official term that they use - so in the opinion of  
6 the medical examiner, this -- the drug found  
7 contributed to the death.

8 And that is then required to be listed  
9 on the death certificate, and they list in no  
10 particular order necessarily, because you can't  
11 tell which drug necessarily -- they're all  
12 combined.

13 They list the drugs on the death  
14 certificate. That data -- and I would also add  
15 that the West Virginia Medical Examiner data is  
16 considered some of the top data in the country in  
17 terms of the compilation of this data onto the  
18 death certificate.

19 And then they -- from 2001 onwards,  
20 because of the problems that we were talking about  
21 earlier, about getting the actual accidental, which  
22 ones are drugs, what drugs were involved, the state  
23 set up a separate system where they listed every  
24 single drug that was believed to be contributing.

1                   That's actually in what they call Part  
2                   I of the death certificate, which are drugs that  
3                   are believed to have contributed to the death. And  
4                   that is what this data is based upon.

5                   So it's a sequential from a detailed  
6                   toxicology coming down to being written on a death  
7                   certificate, being then written into a database at  
8                   the Vital Statistics office.

9                   Q.     In short, it's medical examiner data which  
10                  is used in order to generate the information  
11                  summarized in Figure 1. Correct?

12                 A.     Exactly.

13                 Q.     Now, turning back to the summary on -- in  
14                  the first paragraph on page 5 of your report, and  
15                  turning back to the opinion we've been discussing  
16                  that "fatal overdoses due to prescription opioids"  
17                  "significantly exceeded the rate of fatal overdoses  
18                  due to illicit opioids," Doctor, is that opinion  
19                  specific to Cabell County?

20                 A.     It is -- the figure on page 11 is very  
21                  specific to Cabell County. It also -- it also  
22                  occurred in the state, but that's -- the data there  
23                  is very specific to Cabell County.

24                 Q.     Do you have the same opinion as with regard

1 to West Virginia as a whole?

2 A. Generally, yes.

3 Q. And what is the basis for your opinion with  
4 regard to the state of West Virginia as a whole?

5 A. That is looking at that same database that  
6 we have. Actually, I don't -- I don't think I  
7 included that, but we have access and we have  
8 looked at the data. It's the same database.

9 There's a total for the state, and  
10 then it's broken out for which county.

11 Q. And so you just said you don't think you  
12 included it. Do you mean that you didn't cite it  
13 in your report?

14 A. I'm honestly not sure. I would have to go  
15 back and look. I may do --

16 But the report was concentrating on  
17 Cabell County, and where we didn't have data, we  
18 would include it.

19 I think we're only talking Cabell  
20 County, is what's presented in the report. I would  
21 have to go back and check.

22 Q. Doctor, to the best of your knowledge as  
23 you sit here today, you are not offering an opinion  
24 as to the comparative rates that prescription



1     opioid overdoses and illicit opioid overdoses in  
2     the state of West Virginia for the period of 2001  
3     to 2011; is that right?

4           A.     No, to the best of my knowledge, at the  
5     moment, we don't report the data for the state,  
6     because it was not --

7           Q.     Okay. It's not cited in your report,  
8     right?

9           A.     That -- as far as I know at the moment. I  
10    can't remember whether we would have cited it. The  
11    --

12          Q.     Okay.

13          A.     What we do cite is the accidental poisoning  
14    as a whole, of which the opioids are part of. In  
15    that, we look at the state, because that was the  
16    only data that we had available.

17          Q.     Okay. Now, Doctor, again, this is just for  
18    clarity. When you say "we," do you mean you  
19    personally or --

20          A.     Me. I --

21          Q.     Okay.

22          A.     I'm originally from New Zealand, and we use  
23    the "we" as a personal we sometimes.

24          Q.     In my family, that's what we say "the royal

1 we."

2 A. "The royal we."

3 Q. Okay.

4 A. Exactly what my -- same thing.

5 Q. Fair enough. I just wanted to make sure  
6 the record was clear on our pronouns.

7 Okay. So if we stick on page 5 and we  
8 go to the second paragraph on that page, it says,  
9 "I have further found that for West Virginia, the"  
10 - and I'm going to say - "accidental," as amended,  
11 "poisoning rates, which are mostly due to drugs,  
12 had very low rates from 1979 until 2000 and began  
13 to increase dramatically from 2001 on, when they  
14 began to exceed the rate for the US as a whole."

15 Do you see that, Doctor?

16 A. Yes.

17 Q. What is the basis for your opinion that's  
18 summarized in this second paragraph?

19 A. It's from looking at the U.S. rates as a  
20 whole. For example -- and I think it's -- at this  
21 stage, it's my opinion. But if you look at Figure  
22 3, you could estimate what the rates were for  
23 poisoning and drug poisoning, and then you could  
24 look at the rates for West Virginia and compare it

1 as a whole.

2 So that would -- it's visually  
3 comparing that and I -- I think it was also  
4 mentioned - I'm pretty sure - in the report that's  
5 Appendix -- I'm just going to get the name.

6 Yes. West Virginia -- Appendix --  
7 oops it's here. Exhibit C. Exhibit C is West  
8 Virginia Historical Drug Overdoses. I suspect  
9 that's where I saw this mentioned.

10 I would have to look --

11 Q. Now, that --

12 A. -- at the exact page, but they do talk  
13 about the increase -- in fact that was when they  
14 began to realize -- aah, here you can see. On page  
15 5 of that Exhibit C, you can see West Virginia  
16 compared to the U.S. And they go back to 2001.  
17 But you could see how the West Virginia rates are  
18 clearly exceeding the U.S.

19 Q. Okay. So Doctor, if we look back at page 5  
20 of your report, the second paragraph which we were  
21 just reviewing, accidental poisoning rates as  
22 referenced here, is broader than opioid overdoses.  
23 Correct?

24 A. Correct.

1 Q. It includes, for example, alcohol  
2 poisoning. Correct?

3 A. Yes.

4 Q. Or cocaine poisoning, correct?

5 A. Correct.

6 Q. And the opinion which is set forth here in  
7 the second paragraph relates to the state of West  
8 Virginia as a whole. Correct?

9 A. Correct.

10 Q. It is not specific to Cabell County,  
11 correct?

12 A. We were not able to get the data for Cabell  
13 County. Because the rates were so low that they  
14 suppressed them and -- if the rates of -- or the  
15 cases that count is very low, the National Center  
16 for Health Statistics suppress the rate.

17 Q. So you have not conducted a similar  
18 analysis that is specific to Cabell County,  
19 correct?

20 A. I would dis -- I tried. I tried to the  
21 best of the available data. I spent a lot of time  
22 trying to get specific Cabell County data. But as  
23 I suggested, the rates were so low - and I state  
24 that in my report - that the C -- that the National

1 Center for Health Statistics has a policy of  
2 suppressing the data if the rates are too low  
3 because they're concerned about being able to  
4 identify individuals.

5 Q. Doctor, do you know if Cabell County  
6 maintained that sort of data for the period prior  
7 to 2001?

8 A. They must have, because if it was higher,  
9 it would have been reflected in the rate for West  
10 Virginia, West -- it would have caused the West  
11 Virginia rate to have increased.

12 Q. Do you know if the state of West Virginia  
13 actually maintained data sourced from Cabell County  
14 for the period prior to 2001?

15 A. They did. They compiled data from all  
16 counties and -- as probably originally, that's  
17 where I spent quite a bit of time when you were  
18 going over the individual time, because I was  
19 trying to find data for Cabell County directly.  
20 But the best I could do was to look at the total  
21 class, that was the accidental poisoning rates.

22 And the thing that impressed me was  
23 the rates were so low that it would be impossible  
24 no matter the rates were high or low, for

1 Cabell/Huntington to make much difference in that.

2 Q. Doctor, are you aware that Cabell County  
3 has made no effort to identify the type of drug  
4 involved in an overdose until at least 2015? Are  
5 you aware of that?

6 A. No, I was not.

7 Q. Did you undertake any investigation in  
8 order to interview officials from Cabell County in  
9 order to determine what data they maintained prior  
10 to 2001 with regard to accidental poisoning rates?

11 A. No.

12 Q. Okay.

13 A. I talked at length with people in Cabell  
14 County and worked with them and met them a number  
15 of times. But no, I haven't.

16 Q. Okay. Thank you, Doctor. Who have you  
17 talked to from Cabell County in connection with  
18 your work in this case?

19 A. Not with this case. I have not talked with  
20 any of the officials in regard to the work on this  
21 case.

22 Q. Okay. And just the same question for the  
23 City of Huntington. Have you consulted with any  
24 officials from the City of Huntington in connection

1 with your work in this case?

2 A. Not with this work in the case, but I've  
3 met them at various times --

4 Q. Okay.

5 A. -- as part of my other work.

6 Q. Okay. So as part of your work outside of  
7 this case, who are the individuals from Cabell  
8 County that you consulted?

9 A. I have met the former -- one of the former  
10 police who was -- chiefs who was head of the Drug  
11 Task Force there before he became the drug czar for  
12 the State.

13 I've met with Jan Rader, who's the EMS  
14 director there. I've talked over the phone to  
15 some of the people doing -- they have a very --  
16 because their rates of drug overdoses were so high,  
17 they developed a model program called quick  
18 response grants where they investigated the  
19 overdoses and got people into treatment. So I've  
20 talked to people about that.

21 They've been very proactive in  
22 prevention, and so in the course of understanding  
23 the drug problem, in fact, I've met with them.

24 MR. BURNETT: Doctor Smith, I assume

1 none of those were in context with the litigation.  
2 But if they were, let us know, and we'll act  
3 accordingly.

4 THE DEPONENT: Absolutely not. It was  
5 in the course of me being new to the state and  
6 wanting to understand the problem, and clearly that  
7 was where the -- some of the heart of the problem  
8 was -- there was clearly a problem there, and they  
9 were doing a lot about it, so as part of me  
10 understanding, I made a point of talking to people  
11 there.

12 BY MS. WU:

13 Q. Doctor, you mentioned that you spoke with  
14 Huntington Fire Chief Jan Rader. Is that right?

15 A. Yes.

16 Q. You spoke to her about the Quick Response  
17 Team, correct?

18 A. I think I -- yes, I -- I think I might have  
19 mentioned it. I honestly can't remember what the  
20 conversation was, but I've talked to members of her  
21 team that do the quick response grant, yes, and I  
22 found out details, because I've been working on a  
23 similar program in one of the other counties  
24 nearby.



1 Q. Understood. Doctor, to the best of your  
2 knowledge, what is the QRT program in place in  
3 Huntington?

4 A. It's a quick response grant, quick response  
5 program where essentially when the EMS are called  
6 to an overdose, a couple -- a day or so later, what  
7 they do is they go back -- these are nonfatal  
8 overdoses, obviously.

9 -- and then they go back to the same  
10 place and identify the individual, along with  
11 people that are skilled in getting people into  
12 treatment and know how to get people access to  
13 treatment, and so it's a way of engaging people in  
14 treatment. And I suspect they -- and they're also  
15 giving them naloxone so that they can prevent drug  
16 overdoses from occurring or they can treat them  
17 themselves.

18 That's part of an outreach --

19 Q. Do you know when -- I'm sorry, Doctor.  
20 Please go ahead.

21 A. No, it's just part of an outreach program  
22 they have to try and reduce their problem.

23 Q. Doctor, do you know when Cabell County  
24 instituted the QRT program?

1           A.    No, I don't. I probably -- I have some  
2 documents back in my office that might be able to  
3 give me when it started. But I don't.

4           Q.    And do you know how the QRT program in  
5 Huntington is funded?

6           A.    As I understand it, they've got some grants  
7 and are funded by the County itself. I'm not 100  
8 percent sure how it's funded.

9           Q.    Are you aware that the QRT program is  
10 funded by Federal grant money?

11          A.    Yes, I -- I am. That's -- I'm not sure  
12 what agency, but I know there is some federal money  
13 involved.

14          Q.    Doctor, based on your earlier testimony,  
15 you believe that the QRT program in Huntington has  
16 been successful in reducing the number of  
17 overdoses. Is that right?

18                   MR. BURNETT: Objection.

19          Q.    You can answer.

20          A.    It's not really my -- I don't know the full  
21 data. I've seen reports, but I don't know and --  
22 it -- basically, I'm not in a position to really  
23 analyze the data at all.

24          Q.    From your conversations with Jan Rader and

1 others from the City of Huntington, do you  
2 understand that the City of Huntington believes  
3 that the QRT program has been successful in  
4 reducing overdoses?

5 A. It --

6 MR. BURNETT: Objection.

7 THE DEPONENT: Okay, I won't answer  
8 that.

9 Q. Oh, you can answer, Doctor.

10 A. No, I won't answer, yeah.

11 MR. BURNETT: Well, when I object like  
12 that, you can answer.

13 THE DEPONENT: Yeah.

14 MR. BURNETT: If I say something about  
15 privilege or something else -- I'll explicitly tell  
16 you --

17 THE DEPONENT: Okay, yeah.

18 A. Certainly they claim that it has been  
19 effective, and I've seen newspaper articles  
20 describing that.

21 Q. Okay. Thank you, Doctor. So you mention  
22 that you also spoke with a number of Cabell County  
23 law enforcement. Is that right?

24 A. I think it was former law enforcement at

1 the time, yes. Jim Johnson was his name.

2 Q. Okay. What was the context of your  
3 conversation with Jim Johnson?

4 A. I had just arrived in the state and a  
5 colleague of mine who worked on drug problems took  
6 me on a little bit of a tour to where the hot spots  
7 of the drug problems in the area were, and they  
8 took me down to Huntington, and where we met with  
9 the people there so I -- so I could understand the  
10 drug problem, because I was new to the state, and  
11 we also went down to Portsmouth in Ohio which is  
12 another area that's --

13 So that was the reason that I went  
14 down there.

15 Q. In what year did you make that visit,  
16 Doctor?

17 A. It probably was 2017. I'd have to look at  
18 records as to when exactly it was.

19 Q. Do you recall anyone else in addition to  
20 Jim Johnson that you met during your visit to  
21 Huntington?

22 A. He had a data analyst with him who did  
23 analyst work, and I think that was probably the  
24 only other time. But I've met with people at

1 Marshall University that have been working on the  
2 drug problem at other times.

3 MR. BURNETT: Counsel --

4 Q. Who are the people --

5 MR. BURNETT: Counsel, I don't mean to  
6 interrupt your flow, but we've been going about an  
7 hour and a half, so when there's a good time, I  
8 think we would appreciate a break.

9 MS. WU: Oh, sure, certainly. Let me  
10 just -- let me just get this question in and then  
11 we can break.

12 A. So who have I met at Marshall? I guess  
13 there's a number of different people. The person  
14 who's the current drug czar there. I've met with  
15 Doctor Baker there. I've been to meetings down  
16 there.

17 I guess it's hard -- I -- I'd have to  
18 look at my names. I'm that particularly good at  
19 remembering specific names, but there are a number  
20 of people.

21 Q. Fair enough, Doctor. Have you spoken with  
22 any individuals from Marshall University in  
23 connection with your work in this case, Doctor?

24 A. Absolutely not.

1 Q. Okay. And I'm sorry, I don't want to delay  
2 you from a break; I just don't want to lose track.  
3 Doctor, you were -- in the context of our  
4 conversation about Huntington's QRT team, you used  
5 the term "nonfatal overdoses." Could you tell us  
6 what you mean there and in your report when you use  
7 the term "nonfatal overdoses"?

8 A. Actually, I don't think I mentioned a lot  
9 about nonfatal overdoses in my report, but these  
10 are ones where -- which would not be covered in our  
11 database whereby the person survived the overdose  
12 and didn't make it to the medical examiner's  
13 office.

14 So that's what I mean by a "nonfatal  
15 overdose."

16 Q. Thank you, Doctor. The nonfatal overdoses  
17 are referenced in terms of the data available to  
18 you in Paragraph 1 of your report which is  
19 Deposition Exhibit No. 3. Doctor, can you identify  
20 any source that you considered in connection with  
21 your opinions in this case that relate to nonfatal  
22 overdoses?

23 A. No, it was not the charge. My charge was  
24 to look at -- for this report, was to look at

1 documenting the fatalities and the trend in the  
2 fatalities. Because that was what my particular  
3 expertise was.

4 Q. Thank you, Doctor. So the opinions that  
5 you're offering in this case are limited to fatal  
6 overdoses and do not account for information  
7 related to nonfatal overdoses. Correct?

8 MR. BURNETT: Objection.

9 A. Yeah, I would have to check my report. I  
10 -- in the context of understanding the problem.  
11 I'm not sure. I'd have to spend about 15-20  
12 minutes reading every single line in my report to  
13 make sure that I didn't make a mention of it.

14 Q. Okay. So the opinions that you're offering  
15 with regard to overdose rates in Cabell County and  
16 West Virginia as a whole are limited to fatal  
17 overdoses. Correct?

18 A. Correct.

19 MR. BURNETT: Objection.

20 Q. You haven't considered data which reflects  
21 overdose information for nonfatal overdoses in  
22 connection with your opinions in this case.  
23 Correct?

24 MR. BURNETT: Objection.

1 THE DEPONENT: So does that mean that  
2 I don't need to answer or --

3 MR. BURNETT: You can answer.

4 THE DEPONENT: Just answer.

5 A. Yeah, no, I haven't. That was not my  
6 charge.

7 Q. Okay. Thank you, Doctor.

8 MS. WU: And why don't we go on a  
9 break.

10 MR. BURNETT: Yeah.

11 MS. WU: Doctor and David, how long do  
12 you want to take?

13 MR. BURNETT: Perhaps 10:45?

14 THE DEPONENT: Yeah, sounds good.

15 MS. WU: Okay, 10:45. Thanks,  
16 everyone. See you soon.

17 VIDEO OPERATOR: Going off the record.  
18 The time is 10:33 a.m.

19 (A recess was taken after which the  
20 proceedings continued as follows:)

21 VIDEO OPERATOR: Now begins Media Unit  
22 2 in the deposition of Gordon Smith. We're back on  
23 the record. The time is 10:50 a.m.

24 BY MS. WU:



1 Q. Doctor, we just took a short break. You  
2 know that you're still under oath, correct?

3 A. Correct.

4 Q. Okay. So we spent a little time before the  
5 break talking about your opinions, and now I want  
6 to talk about the boundaries of those opinions.  
7 Doctor, you aren't offering any opinions about the  
8 conduct of any defendant in this case, correct?

9 A. Not any individual defendant, no.

10 Q. You're not offering any opinions about when  
11 -- whether the conduct of any individual defendant  
12 caused any particular outcome in Cabell County,  
13 correct?

14 A. Not -- not a specific individual defendant,  
15 no.

16 Q. Now, when you say "not a specific  
17 individual defendant," what do you mean by that?

18 A. On page 18 of my report, I referred to the  
19 American Public Health Association comment saying  
20 that "I concur with the Task Force," and as that's  
21 "the industry's credibility is near zero and major  
22 changes in its practices are essential."

23 That was a quote directly from their  
24 report.

1                   So I do make some comment because that  
2                   is an expert report prepared by people I know and  
3                   trust their opinions, but not specifically. That's  
4                   why I was being very explicit with you about the  
5                   individual defendants, I have -- I've made no  
6                   comment whatsoever anywhere in the report.

7           Q.     Okay. Let me try to go through this for  
8           clarity, then we'll return to the statement on page  
9           18. Doctor, you aren't offering any opinions about  
10          McKesson in this lawsuit, correct?

11          A.     Correct.

12          Q.     Doctor, you aren't offering any opinions  
13          about Cardinal Health, correct?

14          A.     Correct.

15          Q.     You aren't offering any opinions about  
16          AmerisourceBergen, correct?

17          A.     Correct.

18          Q.     Doctor, you aren't offering any opinions  
19          about whether the conduct of any of those  
20          defendants - McKesson, Cardinal or  
21          AmerisourceBergen - caused any particular outcome  
22          in Cabell County, correct?

23          A.     Correct.

24          Q.     Doctor, you also are not offering any

1 opinion about the legal duties of the defendants  
2 I've named, McKesson, AmerisourceBergen and  
3 Cardinal, correct?

4 A. Correct.

5 Q. So Doctor, just a moment ago, you  
6 referenced page 18 of your report. And you  
7 specifically quoted a passage on page 18 of your  
8 report which is Deposition Exhibit 3 that says,  
9 "The opioid crisis can be directly tied to  
10 practices adopted and encouraged by opioid  
11 manufacturers and distributors. As such, the  
12 industry credibility is near zero and major changes  
13 in its practices are essential."

14 Have I read that correctly?

15 A. That's correct.

16 Q. Doctor, what is the source of this  
17 quotation?

18 A. The source is the Association of -- it's  
19 Footnote 18 on page 17, "Association of Schools and  
20 Programs of Public Health. BRINGING SCIENCE TO  
21 BEAR ON OPIOIDS Report and Recommendations" of "the  
22 ASPPH Task Force on Public Health Initiatives to  
23 Address the Opioid Crisis" dated November" 19, "p.  
24 32," and I cite the web link for it.

1 Q. Doctor, do you concur with this passage  
2 which you've quoted on page 18 of your report?

3 A. That's what I say. I say, "The more I work  
4 on opioids in West Virginia the more I concur with  
5 the Task Forces conclusion."

6 Q. What is the basis for your concurrence with  
7 the statement on page 18 of your report?

8 A. Having read this report and understanding  
9 the literature from -- in the field, I very much  
10 agreed with their report. I rely a lot on my  
11 opinion. They're people that I trust, people that  
12 I know. Some of them I worked with -- one of them,  
13 I've worked with.

14 And I -- the conclusions that they  
15 came to made a whole lot of sense to me. But I  
16 haven't done the original research on that myself.

17 Q. Have you -- what expertise, if any, have  
18 you used in order to confirm or test the statement  
19 that you've quoted on page 18?

20 A. I first started my scientific career in the  
21 1970s. I've been working as a scientist, as a  
22 researcher in the field, understanding, reading,  
23 being able to interpret that literature makes sense  
24 or not makes sense, and I've read a number of other

1 articles in the past about the drug problems.

2 My own research has been more geared  
3 to the actual specific data with regard to the  
4 mortality and those things, but the conclusions  
5 that these experts in the specific field came to  
6 made sense to me. Otherwise, I would not have made  
7 that opinion.

8 Q. Have you done any work in connection with  
9 your opinions in this case in order to test that  
10 statement?

11 A. My work has been understanding the drug  
12 problem and the -- and the -- and its impact on the  
13 people of West Virginia. And so in that respect, I  
14 have -- everything that I saw in that report,  
15 fitted in and concurred with things that I had read  
16 and people I had talked to over the years.

17 Q. All right. And what expertise, if any,  
18 could you bring to bear in order to test that  
19 statement?

20 A. I'm a scientist, and there are other people  
21 who are contributing specifically even in this case  
22 for the -- that are basically saying -- and they  
23 define it clearly, as I understand it. But  
24 essentially, I myself, in terms of doing research,

1 haven't done all of the components there. I've  
2 done pieces that are referred to.

3 They very clearly talk about the data,  
4 the trends in the drugs that were found in people,  
5 the fact that there were increases in supply. So  
6 that's all consistent with what I've heard. But I  
7 myself have not done research in that area  
8 specifically.

9 Q. You yourself aren't an expert in the  
10 pharmaceutical distribution chain, correct?

11 A. I'm an expert in the whole area of  
12 substance abuse in general, and so it's part of the  
13 whole understanding of the drug problem. So while  
14 I admitted I haven't done on that specific thing,  
15 I'm a scientist; I can read the literature; I can  
16 make my own judgment based on -- as scientists, we  
17 can't do every -- all the research in the world,  
18 one person.

19 We have to rely on experts, and I  
20 relied on them with my understanding of the field  
21 and my experience.

22 Q. Certainly, Doctor. Do you claim any  
23 expertise in the pharmaceutical distribution supply  
24 chain?

1 MR. BURNETT: Objection.

2 A. I understand the way it works. I can  
3 understand the reports and read the literature. So  
4 I haven't done research specifically in that area,  
5 but I can very much interpret their report -- the  
6 studies that have been done in that area.

7 Q. What expertise, if any, do you bring to  
8 your review of reports related to the  
9 pharmaceutical supply chain?

10 A. I bring a -- training as a scientist, many  
11 years of training, experience as a scientist,  
12 reading reports, reading, being able to sort out  
13 which reports make sense to me, which ones don't  
14 make sense, which seems a valid claim, which does  
15 not seem a valid claim.

16 And that's the basis upon which I made  
17 that decision.

18 Q. You think your general knowledge and not a  
19 specific expertise related to the pharmaceutical  
20 supply chain?

21 A. General knowledge to a -- as a medical  
22 physician and as a public health researcher and  
23 understanding the field, it is consistent with the  
24 medical literature.

1 MR. BURNETT: And I'll just --

2 Q. So now --

3 MR. BURNETT: Reminder to give me an  
4 opportunity to object to the question.

5 THE DEPONENT: Yes.

6 MR. BURNETT: I object to that  
7 question.

8 Q. Doctor, I'd like to ask you to take out  
9 another document, hopefully to make this segment of  
10 Q and A more concrete. It's Document No. 8 which  
11 is the study we've been talking about, "BRINGING  
12 SCIENCE TO BEAR ON OPIOIDS" dated November 2019.

13 SMITH DEPOSITION EXHIBIT NO. 8

14 ("BRINGING SCIENCE TO BEAR ON OPIOIDS"  
15 Report and Recommendations from the  
16 ASPPH Task Force on Public Health  
17 Initiatives to Address the Opioid  
18 Crisis dated November 2019 was marked  
19 for identification purposes as Smith  
20 Deposition Exhibit No. 8.)

21 A. So what number is this again?

22 Q. Number 8.

23 A. Number 8. So I'll just check it here. Yep.

24 Q. Okay.



1 A. Okay.

2 Q. Doctor, you reviewed the publication marked  
3 as Exhibit 8 in connection with your report,  
4 correct?

5 A. That's correct.

6 Q. And you cited --

7 A. Sometime ago.

8 Q. And you cited it in Footnote 19 of your  
9 report. Correct?

10 A. I think it's Footnote 18 in my report.  
11 Page 17?

12 Q. Page 17, and then again Footnote 19 which  
13 hangs off the statement that we discussed --

14 A. Yes, I see it. Yes.

15 Q. Okay. Thank you, Doctor. What practices  
16 adopted and encouraged by opioid distributors  
17 identified in Exhibit 8 do you refer to in your  
18 report on page 18?

19 A. I referred to the general Gestalt. I  
20 haven't read this in a while. I was -- other than  
21 recommending -- reading the report and making some  
22 comment because I believed in it. And Judith  
23 Feinberg, someone I worked very closely with, I --

24 It would take me a while. If you'd

1 like me to, I could take some time, but it would  
2 take me time to find that exact place in the  
3 report. Maybe you could --

4 Q. Certainly, Doctor. As you sit here today,  
5 what, if any, conduct by pharmaceutical  
6 distributors can you identify as encouraging  
7 prescription or use of opioids?

8 A. That essentially there was -- okay. Based  
9 on the report and other readings, that there were  
10 excessive amounts of opioids distributed in West  
11 Virginia, including Cabell County as a whole.  
12 There was no -- little good evidence that they were  
13 effective for the management of chronic pain, and  
14 that the risks were understated of addiction for  
15 long-term use.

16 And that's the type of opinion that's  
17 in this report. I would need a little bit of time  
18 to completely nail down exactly what page it was  
19 in. But essentially, the issue is that oversupply  
20 of opioids above what seemed to be needed,  
21 distributing and marketed that they were more  
22 efficacious than they actually turned out to be  
23 from studies who were not done by me, but experts  
24 and referred to in this report, and that there were

1       claims that they were nonaddictive, and based on  
2       the reports and the other experts, that this was --

3               I concurred they made -- the data made  
4       sense to me in the report's conclusions. That was  
5       what made me make that conclusion.

6       Q.     Doctor, in your last answer, you described  
7       changes in prescribing practices. Did I hear that  
8       correctly?

9       A.     Yeah, there were -- from the -- in the  
10      report and in other literature, there have been --  
11      there was an increase, considerable increase, in  
12      prescribing of opioids, yes.

13      Q.     As you sit here today, can you identify any  
14      practices or actions of pharmaceutical distributors  
15      that caused increases in the rates of prescribing  
16      opioid medications?

17      A.     I know in the report, they talk about  
18      increased marketing of drugs, that they were  
19      marketed as being safe and less addictive or  
20      nonaddictive, particularly for people with chronic  
21      pain.

22               That would be -- that's one practice  
23      that I know is in the report.

24               I would have trouble -- and if you

1 want -- I could take a long time to find the  
2 specific point.

3 And that they were considered safer  
4 than -- they were marketed as being safer than  
5 other drugs.

6 Q. Doctor, do you know if pharmaceutical  
7 distributors such as McKesson, Cardinal and  
8 AmerisourceBergen market prescription drugs?

9 A. They distribute -- as -- you quoted that  
10 they are actually distributors. Much of the  
11 marketing is done by the individual drug companies,  
12 and they are the ones that distribute.

13 Q. So the marketing behavior that you've just  
14 referenced is conducted by pharmaceutical  
15 manufacturers as opposed to distributors, correct?

16 A. Correct. The manufacturer -- as I  
17 understand the process, the manufacturers make the  
18 drug and were marketing it, but then the  
19 distributors are the people that distribute the  
20 drug, and they have certain legal obligations that  
21 they have to follow that they distribute -- when  
22 they distribute to individual pharmacies, whether  
23 these seem reasonable or should have been red  
24 flags.

1                   And that's the -- in terms of the  
2     distributing, that's the -- what I understand to be  
3     the issue, is that they should have known that  
4     there were these vast quantities of drugs being  
5     sold to people far in excess of what would normally  
6     have been prescribed.

7           Q.     Thank you, Doctor. My question is: Is  
8     there any marketing practice of the distributors -  
9     including McKesson, Cardinal and ABDC - that you  
10    can identify today that you attribute as having  
11    caused or increased prescribing rates of  
12    prescription opioids?

13                   MR. BURNETT: Objection.

14           A.     Yeah, I do not know how they market the  
15    drugs to individual pharmacies, how they're  
16    involved in the marketing their services as a  
17    distributor. That's not an area that I've studied  
18    in great detail.

19           Q.     That's not an area in which you have  
20    expertise, correct, Doctor?

21           A.     I would say I have expertise to be able to  
22    evaluate the reports and what is read, and as a  
23    general person in the whole area of substance  
24    abuse, epidemiology, it's an important part of

1 understanding the problem.

2 Q. But you yourself have never studied the  
3 conduct of distributors, correct?

4 A. I have not conducted an individual study of  
5 distributors. As a scientist, I've read the  
6 literature and interpreted the reports and have  
7 come to a conclusion based on the literature and  
8 the science that's being presented to me as a  
9 scientist.

10 Q. And the marketing activity that you  
11 referenced a short while ago is marketing engaged  
12 in by pharmaceutical manufacturers, correct?

13 A. As I understand it. But I do not know to  
14 the -- any -- the extent to which a distributor is  
15 also involved in marketing their services to  
16 individual pharmacies.

17 Q. You have no --

18 A. Everybody --

19 Q. -- opinion on --

20 A. Most people selling a product do some  
21 marketing, and I do not know the exact details.

22 Q. Thank you, Doctor. You don't have an  
23 opinion on whether or not pharmaceutical  
24 distributors market prescription opioid products,

1 correct?

2 A. I don't know enough about it. The issue is  
3 that I -- to me, every retailer or distributor that  
4 I've dealt with has marketed their services, and so  
5 this -- I assume there is some marketing of it, but  
6 I do not have exact details of that.

7 Q. It's just an assumption, correct, Doc --

8 A. A supplier with market their services, we  
9 can provide the reliable supply, that's why we  
10 choose, you know, one supplier over another,  
11 whenever we go whatever we're looking for.

12 Q. Okay. But you don't actually have  
13 knowledge of pharmaceutical distributor practices,  
14 correct?

15 MR. BURNETT: Objection.

16 A. I have knowledge because I read the  
17 literature and I interpret the literature and I  
18 trust the judgment of scientists who have read  
19 their work, and as a result of that, that's how I  
20 can form an opinion.

21 But it's a -- I have not studied that  
22 area specifically other than studying it in the  
23 literature and reading the opinions of experts.

24 Q. Now, Doctor, turning back to this segment

1 of your report on page 18 which quotes the ASPPH  
2 Task Force report, you write, "the industry's  
3 credibility is near zero." What's "the industry"  
4 that you've referenced there on page 18 of your  
5 report?

6 A. My understanding of what they were saying  
7 there in that report is the industry as a whole,  
8 and they're talking about -- "the industry" is a  
9 very broad concept going all the way from the  
10 manufacturer of the drug itself, and presumably the  
11 industry goes back to the people that make the  
12 chemicals that the individual drug company makes  
13 its things, and then to the drug distribution  
14 system and the way it's distributed to pharmacies,  
15 and then I assume that they're talking of the  
16 pharmacy as part of the broad issue of the  
17 pharmaceutical industry.

18 I think they're taking a broad  
19 interpretation of it.

20 Q. Is that your interpretation of the term  
21 "industry" as used in your report on page 18?

22 A. That was my understanding, that it was part  
23 of a broad, all the way from the manufacturer to  
24 the ultimate retailer in the distribution chain.



1 Q. Doctor, you just referenced pharmacies  
2 dispense prescription opioids, correct?

3 A. Correct.

4 Q. In your opinion, are pharmacies part of the  
5 opioid industry that you've just described?

6 A. I don't -- that part of the whole  
7 pharmaceutical industry, yeah, they are part of the  
8 chain of delivering of the product to the consumer.

9 Q. Is it your opinion, Doctor, that pharmacies  
10 have zero credibility?

11 MR. BURNETT: Objection.

12 A. I think pharmacies differ. They're all  
13 individuals. Some pharmacies may have very poor  
14 credibility; and other pharmacies may have very  
15 good credibility. And I think there's a big  
16 variation between pharmacies.

17 Once you get to the individual  
18 pharmacy level, it's impossible to generalize, I  
19 think.

20 Q. It's impossible to create general  
21 statements about the industry of pharmacies as a  
22 whole, correct?

23 MR. BURNETT: Object.

24 A. I think there were individual pharmacies

1 that clearly were part of the irresponsibility and  
2 the lacking of credibility that I referred to.

3 Q. Doctor, "yes" or "no"? It is impossible to  
4 make determinations as to the credibility of the  
5 pharmacy industry as a whole. Correct?

6 MR. BURNETT: Objection.

7 A. I can't really say that, because it is a --  
8 the report parcels out individual pieces, but the  
9 general conclusion they came to, that the whole  
10 industry chain as a whole, lacked credibility.

11 Q. Doctor, I'm asking for your opinion.  
12 Doctor, is it your opinion that the pharmacy  
13 industry as a whole lacks credibility?

14 MR. BURNETT: Objection.

15 A. My opinion is that I concur with the Task  
16 Force's conclusion as stated.

17 Q. Doctor, "yes" or "no." Is it your opinion  
18 that the pharmacy industry as a whole lacks  
19 credibility?

20 MR. BURNETT: Objection, asked and  
21 answered, and really outside the scope of his  
22 report.

23 MS. WU: Counsel, this is a quotation  
24 in his report.

1 Q. Doctor, please answer yes or no.

2 A. What are you meaning by the pharmaceutical  
3 industry? Are you meaning the manufacturer? Are  
4 you meaning the whole chain? At which point are  
5 you talking about?

6 Q. Doctor, let me clarify. The objection  
7 seems to have thrown you. A few moments ago, we  
8 talked about the pharmacy industry, meaning  
9 pharmacies that dispense opioids. Do you recall  
10 that?

11 A. So you're talking about local pharmacies as  
12 against the pharmaceutical industry.

13 Q. Doctor, is it your opinion that pharmacies  
14 that dispense prescription opioids have almost zero  
15 credibility?

16 MR. BURNETT: Objection, asked and  
17 answered.

18 You can answer.

19 A. Yeah, as I say, some pharmacies certainly  
20 lacked credibility, but I think at the individual  
21 pharmacy level, it's a -- as a group, there clearly  
22 were people that lacked credibility.

23 Q. You can't make a --

24 A. To blanket the whole industry as a whole is

1 impossible, because there are good players and bad  
2 players, and I think that's clearly documented.

3 Q. Doctors prescribe prescription opioids,  
4 correct?

5 A. Correct.

6 Q. Are doctors part of the prescription opioid  
7 industry that you've referenced on page 18 of your  
8 report?

9 A. Clearly there were some prescriptions --  
10 there are physicians that have been prescribing  
11 probably more than they should have.

12 Q. That's not my question, Doctor. My  
13 question is: Are doctors part of "the industry"  
14 that you've referenced on page 18 of your report?

15 A. I would say so, but I'm not 100 percent  
16 sure. I'd have to go back and look at the report  
17 its a while -- it's a long time since I read the  
18 report, so I -- I can't say that. I would have to  
19 spend some time looking to -- because I agree with  
20 the general statement, but I have -- I did not --  
21 you'll notice I did not break it down by what parts  
22 of the industry I agreed with.

23 I think that the overall system -- and  
24 I think that's what they're meaning there. I would

1 have to look at that.

2 Q. Certainly. Doctor, I'm only asking for  
3 your opinions today. I'm not asking for the  
4 opinions of other authors or individuals. Doctor,  
5 is it your opinion that doctors are part of "the  
6 industry" which you've included in the quotation in  
7 your report on page 18?

8 MR. BURNETT: Objection, asked and  
9 answered.

10 THE DEPONENT: Yeah. Yeah.

11 A. I would say that -- that clearly the  
12 doctors were part of the chain of the industry --  
13 the chain of command -- the chain here, and I would  
14 have to check whether they included doctors as part  
15 of their industry -- under their industry  
16 association.

17 I certainly know that there were  
18 doctors that were overprescribing, but there were  
19 also doctors that were underprescribing opioids.

20 Q. Doctor, it's your opinion in this case that  
21 fatal overdoses were caused by prescription opioids  
22 that were the subject of legitimate prescriptions  
23 in some cases. Correct?

24 MR. BURNETT: Objection.

1           A.     In our analysis of the data, we found  
2     prescription opioids in many of the drug -- most of  
3     the drug overdose cases.

4           Q.     Is it your opinion that the doctors  
5     responsible for those prescription opioids -- for  
6     those prescriptions for those prescription opioids  
7     have zero credibility?

8                     MR. BURNETT:  Objection.

9           A.     That was not part of my report, and I -- I  
10    didn't include that in any analysis.

11          Q.     Doctor, as you sit here today, you don't  
12    have knowledge of the sum and substance of the  
13    quotation included on page 18 of your report taken  
14    from the ASPPH report; is that correct?

15                    MR. BURNETT:  Objection,  
16    mischaracterizes the testimony.

17          A.     Yeah, that is not at all what I have said.  
18    I have read the report sometime ago.  I took a  
19    quick look at the conclusions the other day again,  
20    and I realized that I completely agreed with them,  
21    and my opinion has not changed since I read it, and  
22    that was why I quoted it in the report, because I'm  
23    a public health physician; I work at a public  
24    health school.

1           This was the major attempt by experts  
2     in the field to understand the drug problem and, as  
3     they say, bring science to bear on opioids and  
4     understand the problem, and having read it and  
5     knowing the people that were on it, I felt very  
6     comfortable with their concluding statement, which  
7     really summarized it up.

8           Q.     But you don't have an understanding of what  
9     those authors meant by "the industry's  
10    credibility." Is that right?

11           MR. BURNETT: Objection,  
12    mischaracterizes the testimony.

13           A.     Yes, as I've commented before, by "the  
14    industry," we're talking about the whole supply  
15    chain as a whole, from manufacturer, to the  
16    distributor, to the pharmacist, and probably that's  
17    why I would have to go back and read the report,  
18    because certainly some doctors were  
19    overprescribing.

20           Q.     As you sit here today, can you identify any  
21    practices of the pharmaceutical distributors that  
22    encouraged the use of prescription opioids in a way  
23    inconsistent with the standard of care?

24           MR. BURNETT: Objection.

1           A.     The standard of care as I understand it  
2     from reading the literature, my understanding  
3     there's a -- there are a duty to report to the DEA  
4     on when there seemed to be excessive supply to  
5     individual pharmacies or to particular areas, that  
6     they're under a duty to report that.

7                     And it probably wasn't done. From  
8     what I read in this report, it was not done to the  
9     extent to which it probably should -- which it  
10    should have been.

11          Q.     Doctor, that wasn't my question. But let's  
12    -- let's refine that. In the scope of your  
13    testimony in this case, you are not offering any  
14    opinions about the legal duties of pharmaceutical  
15    distributors, correct?

16          A.     That was never contained in my report, no,  
17    as one of my opinions.

18          Q.     And you are not an expert in the legal or  
19    compliance duties of pharmaceutical distributors,  
20    correct?

21          A.     I'm an expert in substance abuse; I  
22    understand the field. I read the literature and  
23    the legal regulatory part of the process is part of  
24    the things that I --



1 THE COURT REPORTER: I've lost him. I  
2 don't know --

3 MS. WU: Same here.

4 MR. BURNETT: His computer just died,  
5 so we're going to switch cables. Hold on.

6 MS. WU: Okay.

7 VIDEO OPERATOR: This is the  
8 videographer. I'm sorry, I didn't realize I was  
9 muted. I went ahead and went off the record.  
10 Teresa, I went off the record at 11:21.

11 (A recess was taken after which the  
12 proceedings continued as follows:)

13 VIDEO OPERATOR: Now begins Media Unit  
14 3 in the deposition of Gordon Smith. We're back on  
15 the record. The time is 11:24 a.m.

16 BY MS. WU:

17 Q. Doctor, we had a technical issue, and I  
18 believe you may have been speaking when we lost  
19 you. So I'm going to try to go back and retread  
20 the same ground, so I ask for your patience here.

21 Doctor, we were talking about the  
22 standard of care just before our technical issue  
23 arose. Do you recall that?

24 A. Yes, I do.

1 Q. Doctor, in the context of this case, you  
2 aren't offering any expert opinion about the  
3 appropriate medical use of prescription opioids,  
4 correct?

5 A. I am -- my opinion was based on -- based on  
6 reading the literature. I don't fully understand  
7 that question, because I --

8 Could you repeat the question?

9 Q. Certainly. sure. Let me try it again.  
10 Doctor, do you anticipate offering any expert  
11 testimony in this case related to the appropriate  
12 use of prescription opioids?

13 A. Only in the context of prescription -- the  
14 -- when I refer to the report, as to what  
15 encouraged and what -- the -- the crisis can be  
16 tied directly to practices adopted by manufacturers  
17 and distributors. Is that -- actually, they only  
18 talk about opioid manufacturers and distributors.

19 So I think I myself hasn't studied it,  
20 but I've read the literature, and I fully  
21 understand the literature and the arguments on both  
22 sides and came to that conclusion.

23 Q. Okay. So just to make it a little more  
24 narrow, my question relates to the testimony that

1 you will give in this case. Doctor, do you plan to  
2 offer any expert opinions about the appropriate  
3 medical use of prescription opioids?

4 A. Not -- not -- it was not part of the report  
5 that I was asked to do, and the only opinion is  
6 regarding the issue -- the statement that I make  
7 there. Other than that, no.

8 Q. Okay. And Doctor, again, just to -- for  
9 clarity, you aren't offering - and you do not plan  
10 to offer - any expert opinions concerning the  
11 marketing of prescription opioids. Correct?

12 A. Correct.

13 MR. BURNETT: Objection.

14 Q. Doctor, you aren't offering any expert  
15 opinion - and you don't plan to offer any expert  
16 opinion - about whether prescription opioids were  
17 diverted for nonmedical use. Correct?

18 A. That was not a subject of my report.

19 Q. And you don't plan to offer testimony on  
20 that subject at trial, correct?

21 A. No. I make -- I make no distinction in my  
22 report with regard to the illegally-diverted  
23 prescription drugs and prescription drugs. We rely  
24 on the molecule that's found on the people when

1 they die, irregardless of the origin.

2 Q. That's not a distinction that you've made  
3 in forming your opinions in the context of this  
4 case, correct?

5 A. Correct.

6 Q. Doctor, you also aren't offering any expert  
7 opinion on the source of prescription opioids that  
8 were involved in any of the fatal overdoses that  
9 are cited and recorded in your report in this case.  
10 Correct?

11 A. In the data that I talk about in the  
12 report, we don't talk about the origin of them. I  
13 do make a comment and refer to several studies that  
14 did do an in-depth study based on the same medical  
15 examiner data where they did look at the -- either  
16 origin of that drug or whether people had a  
17 prescription.

18 Q. Doctor, you yourself -- and I'll use the  
19 term "origin" for clarity. You yourself are not  
20 offering expert opinions about the origin of the  
21 opioids cited in your report. Correct?

22 A. That -- I'm not offering it with regard to  
23 the -- the actual data on the overdoses that come.  
24 I do refer to several other studies that did, but

1 not in the specific study that I did.

2 Q. And you haven't conducted any independent  
3 analysis of the origin of opioids involved in the  
4 fatal overdoses that is in your report, correct?

5 A. Other than reading the literature, other  
6 studies, no.

7 Q. Doctor, you aren't offering any expert  
8 opinion about what caused opioids to become drugs  
9 of abuse in Cabell County, correct?

10 A. Only to the extent that I am citing the  
11 report from the Association of Schools of Public  
12 Health as to the origin of the drug crisis and  
13 agreeing with their report.

14 But I specifically -- did not talk in  
15 any more detail than that.

16 Q. And as you sit here today, you can't  
17 identify any practices of distributors that are  
18 part of the origin referenced on page 18 of your  
19 report. Correct?

20 MR. BURNETT: Objection.

21 A. I'm not quite -- could you -- I'm not quite  
22 sure exactly what you're getting at here.

23 Q. Sure. As you -- you referenced in your  
24 last answer a quotation on page 18 of your report.

1 Correct?

2 A. Correct.

3 Q. And the quotation that you reference is  
4 from the Association of Schools and Programs of  
5 Public Health's publication dating from November  
6 2019, correct?

7 A. Correct.

8 Q. That report refers to certain practices of  
9 opioid manufacturers and distributors, correct?

10 A. Correct.

11 Q. As you sit here today, you can't identify  
12 any practices of distributors that are referenced  
13 in your report on page 18. Correct?

14 MR. BURNETT: Objection.

15 A. What I do reference is the discussion from  
16 the expert report that -- that there was oversupply  
17 -- overpromotion and marketing by the opioid  
18 manufacturers, and that the distributors  
19 overdistributed, I guess -- basically distributed  
20 higher quantities of drug than would be expected,  
21 and from reading the reports --

22 And that report -- that should have  
23 been reported to the DEA.

24 Q. Doctor, are you offering any opinions as to

1 what amount of prescription opioids should have  
2 been distributed to Cabell County?

3 A. I'm relying on the experts who wrote the  
4 report, and in their opinion, it was excessive. I  
5 do not have an opinion -- other than reading the  
6 expert and that I agree -- my opinion is that I  
7 agree with the report.

8 Q. Doctor, do you know if that report itself  
9 identifies any amount of prescription opioid  
10 distribution to Cabell County that would have been  
11 proper?

12 A. Not to my -- I would have to go through and  
13 do a search for the word "Cabell" to make 100  
14 percent sure. But I'm not aware of that.

15 Q. And as you sit here today, you are not  
16 aware of what interval of oversupply that report  
17 attributes to the distributors, correct?

18 A. That's correct.

19 Q. All right. Doctor, earlier you testified  
20 that the overdoses reported or reflected in your  
21 report, Exhibit 3, are limited to fatal overdoses.  
22 Is that correct?

23 A. Correct.

24 Q. Doctor, do you know what percentage of

1 overdoses in Cabell County for the period 2001 to  
2 2018 were fatal?

3 A. That, I do not know, and I think it's a  
4 very difficult answer. There are different levels  
5 that you could look at, but I'm not aware of the  
6 data. Some people have looked at emergency  
7 department visits, but then once they distributed  
8 naloxone, you can't rely on emergency department  
9 visits because many people are giving naloxone to  
10 friends and colleagues in the field.

11 So it's a difficult -- and I do not  
12 know.

13 Q. You do not know. Do you know what  
14 percentage of overdoses are addressed in your  
15 report for Cabell County?

16 A. In terms of fatal overdoses, the general  
17 feeling of the literature and the quality of the  
18 medical examiner data and the Vital Statistics in  
19 West Virginia is that we're capturing as close as  
20 we can to 100 percent of all of the overdose  
21 fatalities in the state -- in Cabell County and in  
22 the State. But I make no reference to the nonfatal  
23 ones.

24 Q. Doctor, so you don't know what proportion



1 of all overdoses in Cabell County are fatal  
2 overdoses, correct?

3 A. That's -- that's correct. And I think  
4 there -- any attempt to get it would be a  
5 guesstimate, because it's so difficult to know at  
6 what stage of a -- of a very minor overdose might  
7 not need treatment.

8 Q. Doctor, are you familiar with ARCOS data?

9 A. I've seen reference to it, but I have --  
10 and -- in reports, but I haven't looked at it in  
11 detail myself, no.

12 Q. And you haven't looked at ARCOS data in  
13 connection with your work for this case, correct?

14 A. No, I have not.

15 Q. Doctor, do you know the market share of  
16 McKesson in Cabell County?

17 A. No, I do not.

18 Q. Doctor, did you attempt to identify whether  
19 any fatal overdoses which were included in the data  
20 that you summarized in your report were linked to  
21 McKesson?

22 A. It's impossible to tell from the data that  
23 we have the actual origin of either the  
24 manufacturer of the drug or of the person that

1 delivered it to the state. Or the county.

2 Q. So your answer would be the same for  
3 AmerisourceBergen, correct? You haven't attempted  
4 to identify whether any fatal overdose referenced  
5 in your report could be linked to  
6 AmerisourceBergen, correct?

7 A. No. Basically the drugs have to get into  
8 there somehow, but I cannot tell how they got  
9 there.

10 Q. And same answer for Cardinal, correct?

11 A. Correct.

12 Q. Have you undertaken that exercise with  
13 regard to any pharmacy?

14 A. No, I have not personally.

15 Q. Have you undertaken that exercise with  
16 regard to any manufacturer?

17 A. No, I have -- no, I have not, only to the  
18 point - and I would have to go and check - some of  
19 the drugs were under patent at the time, and so I  
20 -- you could potentially go back and identify a  
21 manufacturer, but it would be dependent on which  
22 drugs were under patent and which were not under  
23 patent and were made by the other drug companies.

24 So that would be complicated to work

1 out, but some of it would be possible, but not all  
2 of it.

3 Q. Doctor, do you know if the toxicology  
4 reports generated by the West Virginia Medical  
5 Examiner are sufficiently detailed in order to  
6 identify specific manufacturer of pharmaceutical  
7 products?

8 A. They cannot identify specific manufacturer  
9 of the product. They can identify the specific  
10 drug, and if that drug were under patent and the  
11 only ones -- one manufacturer, they could identify  
12 a manufacturer. But only through that mechanism.

13 Q. And have you done that analysis for  
14 manufacturers potentially tied to fatal overdoses  
15 cited to your report in this case?

16 A. I have not done to individual  
17 manufacturers, but if you look at -- they name  
18 specific drugs such as OxyContin and various other  
19 drugs like that, that for a period of time - and  
20 I'm not sure when it came off patent - was  
21 certainly patented drugs and were only made by a  
22 particular manufacturer.

23 Q. But you haven't done that analysis in the  
24 context of this case, correct?

1           A.     The specific drugs are listed in my opinion  
2     -- in my exhibits as to what drugs, so that if you  
3     wanted to look up which drugs were made by which  
4     manufacturer and which drugs were under patent, you  
5     would be able to do that.

6           Q.     So Doctor, it would be possible, for  
7     example, to identify the number of fatal overdoses  
8     reflected in the data you report which are linked  
9     to a product manufactured by Purdue.

10          A.     If you wanted to go back and study the  
11     period that Purdue was the only manufacturer of  
12     OxyContin and then look at when other manufacturers  
13     started manufacturing it. So it would be possible  
14     if you wanted to do that directly from the data.

15          Q.     Now I want to move on to doctors. Doctor,  
16     have you attempted to identify whether any of the  
17     fatal doses -- overdoses which are identified in  
18     your report in this case can be linked to a  
19     particular prescribing physician?

20          A.     No, I have not. And the PDMP is  
21     restrictive and you can't get that.

22          Q.     Doctor, when you say "PDMP," what are you  
23     referring to?

24          A.     Prescription Drug Monitoring Program.

1 Q. Are you referring to the West Virginia  
2 PDMP?

3 A. Yeah, that's called the controlled  
4 substances monitoring board.

5 Q. Did you review PDMP data in connection with  
6 preparing your report in this case?

7 A. Not directly, I did not. The only  
8 reference I make is in the two specific studies  
9 that did do some linkage with the PDMP data.

10 Q. You yourself haven't tested those findings  
11 by doing your own analysis of the PDMP data,  
12 correct?

13 A. That's correct. I relied on other reports.

14 Q. Doctor, we've talked a little bit about the  
15 role of distributors over the last few minutes.  
16 Doctor, if McKesson ceased distributing opioid  
17 medications in Cabell County, would the opioid  
18 crisis in Cabell County be any different than it is  
19 today?

20 MR. BURNETT: Objection, calls for a  
21 legal conclusion.

22 A. Now, I'm honestly not sure. It would -- it  
23 would depend on what proportion of the market share  
24 -- I honestly don't know.

1 Q. And so your answer would be the same for  
2 ABDC and Cardinal. You don't know what impact  
3 distribution by ABDC, Cardinal and McKesson would  
4 have on the rates of overdose in Cabell County,  
5 correct?

6 MR. BURNETT: Objection, calls for a  
7 legal conclusion.

8 A. Yes, I -- I don't think I could do that  
9 because -- and it would depend -- if they hadn't  
10 distributed in the first place, then maybe it may  
11 have had an impact. But I don't know.

12 Q. That's not something on which you have an  
13 opinion in this case?

14 A. That's correct.

15 Q. Doctor, you're not an expert in assessing  
16 criminal organizations that traffic drugs into  
17 Cabell County in West Virginia, correct?

18 A. I have read reports and I have a knowledge  
19 of the DEA reports and the way that these things  
20 are done, but I haven't done individual studies  
21 myself.

22 Q. Do you claim expertise in criminal drug  
23 trafficking organizations?

24 A. I have a good knowledge as a researcher

1 because it's part of the field of drug abuse, but I  
2 haven't done specific studies in that area myself.

3 Q. And you haven't published any peer review  
4 articles which analyze or review the role of drug  
5 trafficking organizations, correct?

6 A. That is correct.

7 Q. Doctor, you did not consider the effect of  
8 criminal drug trafficking organizations in forming  
9 your opinions in the context of this case, correct?

10 A. Did -- no. No.

11 Q. However, you are aware that criminal drug  
12 trafficking organizations sell opioids in Cabell  
13 County, correct?

14 MR. BURNETT: Objection.

15 A. I -- I guess criminal drugs are selling  
16 opioids anywhere in the country and I see a risk --  
17 data -- I've seen a risk for it, yes. So the  
18 answer is yes.

19 Q. Your report, Doctor, doesn't address the  
20 extent to which the activity of drug trafficking  
21 organizations has contributed to the opioid crisis  
22 in Cabell County, correct?

23 A. That's correct.

24 Q. And so it follows that you didn't attempt

1 to determine whether any specific fatal overdose  
2 referenced in your report can be traced to the  
3 activity of a criminal drug trafficking  
4 organization, correct?

5 A. No, my report can only determine that it  
6 was a prescription drug versus the illegal drugs  
7 that were not part of the DEA's Schedule I.

8 Q. Now, Doctor, I'd like to turn back to your  
9 report which is Exhibit 3 and look at page 10 of  
10 the report.

11 A. Yes.

12 Q. And I can call your attention to -- I guess  
13 it's one paragraph that we're looking at here on  
14 page 10. Let's see -- the seventh line from the  
15 bottom, there's a sentence that reads, "The data  
16 therefore support the recognized transition from  
17 prescription to illicit opioid use, which has been  
18 documented in numerous peer-review studies at the  
19 US population in general."

20 Do you see what I've read?

21 A. Yes.

22 Q. Doctor, you -- in this portion of your  
23 report on page 10, you are not offering opinions  
24 about what caused the transition from prescription



1 to illicit opioid use, correct?

2 A. No, I'm not. I'm relying on the studies  
3 that -- and -- that -- my finding of the changes  
4 support the recognized transition from prescription  
5 to illicit opioids.

6 Q. And you just mentioned the sources that you  
7 cite. If we look down at -- still on page 10, at  
8 Footnote 9, you cite two academic articles. Do you  
9 see that?

10 A. Yes, I do.

11 Q. All right. Doctor, neither of those  
12 articles find a causal relationship between  
13 prescription opioids and illicit opioids; is that  
14 right?

15 A. I -- it's a while since I read them. All I  
16 can say at this stage is that what I wrote in my  
17 report, that they support this recognized  
18 transition from prescription to illicit opioids,  
19 and you're seeing that in my report, whereby -- on  
20 page 11, the next page over, Figure 2, you will see  
21 an increase in the illicit drugs, but still the  
22 prescription drugs maintained.

23 We're still finding prescription drugs  
24 even in those people.

1 Q. Right. But you aren't offering an opinion  
2 as to the causal relationship between prescription  
3 opioids and illicit opioids, correct?

4 A. I'm not offering a causal relationship.  
5 I'm just saying that we find -- continue to find  
6 prescription drugs even when the illicit drugs were  
7 -- began to be a problem.

8 Q. Okay. And then if we continue, it says -  
9 back on page 10 - "and in Erik Eyre's recent book  
10 which describes how the same thing occurred  
11 throughout WV, including in Cabell County."

12 Do you see where I've read that?

13 A. Yes.

14 Q. And at Footnote 10, it cites Erik Eyre's  
15 book "Death in Mud Lick." Do you see that?

16 A. Yes, I do.

17 Q. Doctor, who is Erik Eyre?

18 A. Erik Ayers was a reporter for the capital  
19 Gazette -- I think that's the Charleston -- the  
20 main Charleston newspaper.

21 Q. He's not an epidemiologist, is he?

22 A. That's correct.

23 Q. And his book hasn't been peer reviewed,  
24 correct?

1 A. No, it has not.

2 Q. Doctor, now I'd like to --

3 A. But -- he -- yeah, yes. Okay, yeah.

4 Q. Doctor, I'd now like to ask you to take out  
5 another document, which is Exhibit 5, which is a  
6 copy of your CV.

7 MR. BURNETT: Ms. Wu, I'd note we've  
8 gone about an hour, so you know, whenever is a good  
9 time for a break, I would suggest one.

10 MS. WU: Sure. I'm happy to break now  
11 if you'd like to break now.

12 MR. BURNETT: What do you think, do  
13 you like to break now?

14 THE DEPONENT: Yeah, I wouldn't mind a  
15 little break now -- yes.

16 MR. BURNETT: Yeah, you want to break  
17 now? It doesn't have to be a lunch break. We're  
18 still waiting on lunch for us. Why don't you go  
19 off the record.

20 MS. WU: Okay. Sure.

21 VIDEO OPERATOR: Going off the record.  
22 The time is 11:47 a.m.

23 (A recess was taken after which the  
24 proceedings continued as follows:)

1 VIDEO OPERATOR: Now begins Media Unit  
2 4 in the deposition of Gordon Smith. We're back on  
3 the record. The time is 12:35 p.m.

4 BY MS. WU:

5 Q. Good afternoon, Doctor. We just took a  
6 break. You understand that you're still under  
7 oath, correct?

8 A. Yes, that's correct.

9 Q. Okay. Thank you, Doctor. I'd like to pick  
10 up where we left right before the break. Before  
11 the break, you testified that -- I asked you when  
12 you look at overdose deaths, whether it's possible  
13 to determine the origin of the drugs involved in  
14 the fatal overdose. Do you recall that?

15 A. Yes, I do.

16 Q. You stated that you can only determine  
17 whether it's prescription drugs on the one hand,  
18 versus illegal drugs not part of the PDMP. Do you  
19 recall that testimony?

20 A. Yes, I do.

21 Q. Doctor, simply because someone has a  
22 prescription drug found in his system at the time  
23 of death does not indicate that the prescription  
24 drug was legally obtained. Correct?

1 A. That's correct.

2 Q. It doesn't tell you either way, correct?

3 A. Yes, that's correct.

4 Q. In fact, the study that you cite, the Smith  
5 study, found that in the vast majority of fatal  
6 overdose deaths, more than 63 percent had  
7 prescription opioids in their system at the time of  
8 death, but the decedent did not have a prescription  
9 from a physician. Correct?

10 A. That was, I think, the distinction we made  
11 between the males and females. I'll go back and  
12 look at that. Let me see that here.

13 MR. BURNETT: Ms. Wu, are you quoting  
14 something from his report that I could look at?

15 MS. WU: I'm asking a question based  
16 on his testimony earlier. Actually, the witness  
17 can answer based on his knowledge and his report.

18 A. Yeah, it was in my report.

19 Yeah, that's right, 63.1 percent were  
20 found to not have a documented prescription for the  
21 actual drug found. But the important part was that  
22 36.9 percent had active prescriptions at least for  
23 some of the drugs and -- when they died. And --  
24 yep.

1 Q. So --

2 A. That was the 2006 study. Yes, exactly.

3 But then the more recent one --

4 Q. Doctor --

5 A. Carry on.

6 Q. Doctor, based on the data indicating that  
7 63 percent of decedents did not have a valid  
8 prescription for prescription opioids, you found  
9 that those -- that data suggested diversion,  
10 correct?

11 A. That's suggesting it, yes.

12 Q. And diversion is criminal activity,  
13 correct?

14 A. Correct.

15 MR. BURNETT: Objection.

16 A. It may be criminal activity; it may be  
17 someone taking -- a son or a partner taking the  
18 drug of somebody else in the same household, which  
19 probably doesn't involve criminal activity.

20 In fact, there's some evidence in a  
21 lot of younger people, that's actually what happens  
22 in some of them, but --

23 Q. Doctor, do you know if it's illegal to take  
24 the -- a prescription medication prescribed to

1 another individual?

2 A. That's a legal opinion. I'm not 100  
3 percent -- I'm not 100 percent sure of the actual  
4 legality of that, to be honest.

5 Q. Okay, fair enough. Doctor, a few minutes  
6 ago, you also referenced the statistic that 36 -- I  
7 think you said 36.9 percent of the decedents  
8 studied in the 2006 study cited in your report had  
9 a prescription for at least one of the drugs found  
10 in their system at the time of death. Correct?

11 A. That's correct.

12 Q. It's not the case that the decedents had a  
13 prescription for all of the drugs found in their  
14 system at the time of death. Correct?

15 A. Correct.

16 Q. A prescription for controlled substances  
17 isn't valid for a full year, correct?

18 MR. BURNETT: Objection.

19 A. I'm not sure about the legality of that.  
20 It's not an area I've studied.

21 Q. Doctor, do you know that prescriptions for  
22 Schedule II substances are not valid beyond 90  
23 days?

24 A. I'm -- I'm not 100 percent sure that. That

1 sounds reasonable, but I don't know for sure.

2 Q. You don't know. If we assume that it is  
3 the case that Schedule II substances are only valid  
4 -- prescriptions for Schedule II substances are  
5 only for -- only valid for 90 days, it follows that  
6 a person who is prescribed a controlled substance  
7 more than 90 days prior to the time of death used  
8 the prescription in a criminal way. Correct?

9 MR. BURNETT: Objection, calls for  
10 speculation.

11 A. Yeah, no, I don't know that for sure at  
12 all. I -- it's hard to say.

13 MR. BURNETT: Again -- Doctor --  
14 Doctor Smith, when -- in a case like that where I'm  
15 objecting, as with Ms. Wu, just make sure that you  
16 let me say the full objection --

17 THE DEPONENT: Yes.

18 MR. BURNETT: -- before you answer so  
19 that we don't overlap each other.

20 THE DEPONENT: Thank you.

21 MR. BURNETT: Thanks.

22 Q. Okay, Doctor, maybe we can simplify this  
23 and take it outside of criminal terms. The 2006  
24 study that we're discussing, the Hall study, didn't



1 identify the number of individuals cited in the  
2 study who had a valid prescription for an opioid  
3 medication at the time of death when drugs were  
4 found in their system. Correct?

5 A. Yes. I must say - and I didn't put it in  
6 my report - I'm not sure how far back they looked  
7 for their prescription. I know in the latest  
8 study, they only looked at controlled substances  
9 prescriptions 30 days prior to death.

10 They may have done the same thing with  
11 this, and I don't know. I would have to go back  
12 and check the article - and I don't have it with me  
13 - to determine how far back they looked for the  
14 prescription.

15 Q. You don't have any --

16 A. Because your suggestion --

17 Q. You're talking about the Hall study  
18 published in 2006.

19 A. Yes.

20 Q. You don't know if that study identified the  
21 number of individuals who had a valid prescription  
22 at the time of their death. Correct?

23 A. That's what I don't know. But it says  
24 here, 39 -- 36.9 had active prescriptions, and I'm

1     guessing that's probably a quotation from their  
2     study, meaning that probably it was within the  
3     valid prescription.

4                 I would have to check that with the  
5     original article, and I'm not sure. And you can --

6     Q.     And you don't know that one way or the  
7     other?

8                 MR. BURNETT: Objection.

9     A.     Yeah, because they do say "active  
10    prescription." And to me, an active prescription  
11    would be one that was legal. But I don't know for  
12    sure.

13    Q.     You don't know that?

14                 MR. BURNETT: Objection.

15    A.     Agreed. I don't know. I would have --  
16    would not have put "active" down after having read  
17    it if I didn't think that it was a valid  
18    prescription at the time, but I don't know for  
19    sure.

20                 I would have to check that. And I do  
21    know that the -- the two thousand and -- the more  
22    recent study, they probably followed the same  
23    methodology, and they talk about 30 days prior to  
24    death.

1                   But I don't know.

2           Q.     You -- as you sit here today, you don't  
3 know one way or another?

4           A.     No. But you could easily check that by  
5 looking at the article.

6           Q.     Right. I'm looking for your knowledge as  
7 you sit here today.

8           A.     Yep.

9           Q.     Doctor, if we say we're talking about the  
10 2006 study, the Hall study, you also -- it also has  
11 a finding that 21.4 percent of all decedents had  
12 obtained prescriptions from five or more doctors.  
13 Do you recall that?

14          A.     Exactly, yes.

15          Q.     Are you familiar with the term "doctor  
16 shopping"?

17          A.     Yes, I am. I put the term down in my  
18 report.

19          Q.     Doctor shopping is a form of diversion,  
20 correct?

21          A.     I --

22                   MR. BURNETT: Objection.

23          A.     I'm not sure whether it's considered  
24 diversion because it's to the same person. I don't

1 understand the legal -- legality whether it's  
2 considered diversion or not.

3 Q. Fair enough. You understand that doctor  
4 shopping means seeking prescriptions in a way  
5 inconsistent with the standard of care. Correct?

6 MR. BURNETT: Objection.

7 A. Probably. It's generally considered to be  
8 not a good practice.

9 Q. And therefore, prescriptions obtained  
10 through doctor shopping would be taken in the form  
11 of nonmedical use, correct?

12 MR. BURNETT: Objection.

13 A. I honestly don't know. Because many of  
14 these people have valid pain and they seek -- and  
15 also looking at this, I don't know, and I don't  
16 have all the details in front of me.

17 It's five clinicians in the past year.  
18 They could have just moved. That doesn't prove  
19 doctor shopping, but I think it suggested it.

20 Q. And you have no opinion on whether or not  
21 doctor shopping is criminal activity, correct?

22 A. I don't know the legality of it, the strict  
23 legality of it.

24 Q. Okay. Now, a few moments ago, you cited "a

1 more recent report." Were you referring to the  
2 2017 report published by the West Virginia  
3 Department of Health and Human Services?

4 A. Yes, that's correct.

5 Q. Doctor, that report assessed 830 overdose  
6 deaths across the state of West Virginia in 2016,  
7 correct?

8 A. Yes.

9 Q. That report was --

10 A. 2016, yes.

11 Q. That report, the 2017 report, was not  
12 limited to Cabell County, correct?

13 A. Correct.

14 Q. So Doctor, I now want to go back to talk a  
15 little bit more about the data that you relied on.  
16 And if you have handy -- sorry, we've been moving  
17 around to some of your other sources.

18 -- Exhibit 3, your report. And if you  
19 turn to page 5 --

20 A. Exhibit 3, page 5. Yep.

21 Q. Doctor, on page 5 of your report, you state  
22 that "West Virginia has some of the highest  
23 quality" and -- I'm sorry. The medical examiner  
24 data in West Virginia is, quote, "some of the

1 highest quality in the country, especially for drug  
2 overdoses and information on actual drugs  
3 involved."

4 Do you see that?

5 A. That's page 5 of my report or of the --

6 Q. Of your -- of your report.

7 A. Of my report, okay. Yes, I do. That's  
8 correct. I'll go back to page 5 of my report. I'm  
9 a little --

10 Yes.

11 Q. Doctor, are you familiar with the National  
12 Association of Medical Examiners?

13 A. Yes, I am.

14 Q. Are you aware that the National Association  
15 of Medical Examiners accredits state medical  
16 examiners?

17 A. Yes, I am.

18 Q. Are you aware that West Virginia -- the  
19 West Virginia Office of the Medical Examiner is not  
20 accredited?

21 A. I'm not aware of that, but I am aware that  
22 the laboratory upon which the toxicology is an  
23 accredited -- the last time I looked, was an  
24 accredited laboratory for the toxicology testing.

1 Q. And as you sit here, Doctor, you don't know  
2 whether the West Virginia Office of the Chief  
3 Medical Examiner is accredited by the National  
4 Association of Medical Examiners, correct?

5 A. I'm not aware of that. I do know -- yes,  
6 I'm not aware.

7 Q. Doctor, you didn't personally conduct any  
8 of the autopsy or toxicology screens for the  
9 individuals who died of drug overdoses discussed in  
10 your report, correct?

11 A. I did not, but I'm very familiar with the  
12 procedures. I've been working with medical  
13 examiner data and been part of observing autopsies  
14 probably 25 years in terms of work I did in  
15 Maryland and work here, so I'm very familiar with  
16 the practices and the way in which they do things.

17 Q. Doctor, but you don't personally conduct  
18 the autopsies or tox screens yourself, correct?

19 A. I didn't conduct them, no, but I'm very  
20 well aware and understand fully the procedures  
21 involved.

22 Q. Doctor, did you review the procedures by  
23 which medical examiners in West Virginia conduct  
24 autopsies and toxicology screens which are

1 referenced in your report?

2 A. To the extent that I have co-published  
3 articles with them, both the toxicologists and the  
4 medical examiner, where we have written up  
5 procedures that have passed peer review -- reviewed  
6 by other people and their procedures, all of the  
7 documentation that I had seen, looked to be very  
8 appropriate and also were considered to be adequate  
9 by peer reviewers to allow our articles to be  
10 published.

11 Q. Doctor, in West Virginia, medical examiners  
12 that provide data to the State Office of the Chief  
13 Medical Examiner do not need to be licensed  
14 physicians, correct?

15 A. The -- could you just repeat that again?  
16 So who --

17 Q. Certainly. The local medical examiners who  
18 report --

19 A. Oh, yes.

20 Q. -- data to the state do not have to be  
21 licensed physicians, correct?

22 A. That's correct.

23 Q. Do you know what individuals reported  
24 medical examiner data for Cabell County to the



1 state?

2 A. It's a matter of what you're talking about  
3 by the report. From the procedures that I know, is  
4 that they have a locally-appointed medical examiner  
5 that's often a nurse, a emergency medical  
6 physician, someone who's taken a course in how to  
7 do the technical field work, and then that case is  
8 then reported to the medical examiner himself who  
9 is a licensed forensic pathologist, and they are  
10 the ones who do the autopsy and the toxicology.

11 Whereas the field work at the -- in  
12 the county is not done necessarily by a licensed  
13 physician. Sometimes it is.

14 Q. Doctor, do you investigate who was  
15 responsible for the field work, as you've referred  
16 to it, for Cabell County?

17 A. I am -- I do not know, haven't investigated  
18 myself, but it would be part of the team, and they  
19 are under the supervision of the medical examiner.

20 Q. But that's not something you've  
21 investigated for purposes of forming your opinions  
22 in this case, correct?

23 A. That's -- that's correct, because most of  
24 my data is based on actual toxicology that is

1 performed at the medical examiner's office where I  
2 do know much more about the procedures.

3 Q. Okay. Doctor, a few minutes ago, you  
4 referenced the chief medical examiner that you  
5 co-authored an article with. Are you referring to  
6 Doctor Mock?

7 A. That's correct.

8 Q. Have -- are you aware that Doctor Mock was  
9 deposed in this litigation?

10 A. I think I remember hearing that, yes. I  
11 don't know any details.

12 Q. Did you review his deposition transcript --

13 A. No, I --

14 Q. -- in order to form your opinions?

15 A. No, I --

16 Q. In order to form your opinions in this  
17 case?

18 A. My opinion for this case was based entirely  
19 on the -- the discussions regarding our  
20 publications, our peer reviewed publications, and  
21 the documentation that they provided when we have  
22 written the article and where there would have been  
23 errors, they would correct it.

24 Q. So Doctor, earlier today you referenced

1 West Virginia's Controlled Substances Monitoring  
2 Program or CSMP, correct?

3 A. Correct.

4 Q. Doctor, are you aware that the West  
5 Virginia Office of the Chief Medical Examiner does  
6 not require doctors conducting autopsies to record  
7 information obtained from the CSMP?

8 A. I am not aware that -- I'm not sure. There  
9 was this original study done, and I'm not sure  
10 whether they kept the procedures up.

11 Q. Okay. Doctor, do you know if individuals  
12 conducting autopsies -- autopsies on behalf of the  
13 West Virginia chief medical examiner are required  
14 to consult CSMP data?

15 A. I am not aware of that exact procedure, and  
16 I've not included that in my own original research.  
17 We've just been interested in the toxicology.

18 Q. And the CSMP data could be used to identify  
19 prescription drug histories for decedents, correct?

20 A. It has been done, and that's why I made a  
21 point of using the data from these two separate  
22 reports and two separate time periods, which I  
23 quoted in my report.

24 Q. But as -- but as you sit here today, you

1 don't know if consultation of the CSMP is required  
2 by the chief medical examiner's autopsy protocols,  
3 correct?

4 A. I do not know that.

5 Q. Doctor, do you know the extent of the data  
6 which is input into the CSMP?

7 A. By "extent," inputted -- put in by whom?  
8 Because it comes from different places. The  
9 pharmacy and the physicians are also required to  
10 check it.

11 Q. Sure. Let me try to make this more  
12 concrete. Doctor, are you aware that the Veterans  
13 affairs system did not report prescriptions to the  
14 CSMP for many years?

15 A. Yes, I -- I am aware that there have been  
16 problems with the federal system -- some of the  
17 federal health care systems reporting. I don't  
18 know the period of time, and I'm -- but I have the  
19 impression that they have fixed that, but I'm not  
20 sure.

21 Q. Have you done any work to test the  
22 reliability of West Virginia's CSMP system?

23 A. You know, it's not been the subject of this  
24 report. It was not something I was asked to do.

1 And I have not done that.

2 Q. Doctor, are you aware that West Virginia  
3 first established its forensic drug database in  
4 2005?

5 A. Yes, I am.

6 Q. So prior to that year, 2005, the  
7 information in the forensic drug database might not  
8 have been collected in any centralized fashion.  
9 Correct?

10 A. I would disagree. It was -- the database  
11 was set up specifically originally to actually look  
12 at the multiple drug combinations. But prior to  
13 that, the medical examiners continued -- have been  
14 doing the exact same procedure, doing their tests,  
15 reporting the results out and writing them on the  
16 death certificate.

17 So it's more that there was a separate  
18 reporting system established in 2005 for their  
19 toxicology, and the original purpose behind it was  
20 to -- because they were concerned that no one drug  
21 was high enough concentration to kill a person, and  
22 it was a combination of drugs that resulted in it.

23 And -- but before that, they were  
24 doing the standard procedures. The same data would

1 make it on to the death certificates.

2 So prior to 2005, the same data would  
3 make it on to the death certificate which would  
4 then make it down to Vital Statistics, and then we  
5 also have been paying people since 2005 to abstract  
6 that same data and put it into the forensic drug  
7 database.

8 Q. So prior to 2005, the data currently  
9 contained the forensic drug database was not  
10 centralized in the same manner it began being  
11 centralized in 2005, correct?

12 A. I don't know about "centralized."

13 MR. BURNETT: Yeah, I object.

14 A. I don't know about being centralized. I  
15 think it's more that the data was part of the  
16 process, and this was an add-on, an additional step  
17 to capture the multiple drug. And in particular,  
18 it captures the concentration of the drugs, which  
19 is not listed on the death certificate.

20 Q. Do you have any understanding of the  
21 incremental benefit of implementing the forensic  
22 drug database in 2005?

23 MR. BURNETT: Objection.

24 A. Yes, I don't know what you're -- what

1     you're trying to get -- certainly not been the  
2     subject of my report, and it would -- I would have  
3     to go back and check with my colleagues on that.

4             I don't think it has affected at all  
5     the quality of data that makes it to the death  
6     certificate.

7             Q.     Have you done any testing of the  
8     reliability of forensic drug data available prior  
9     to 2005 and after 2005?

10            A.     No, I have not done -- the -- perhaps the  
11     best source was that detailed study that the CDC  
12     did, the Hall study. They did a detailed study of  
13     the medical examiner data, and as I understand it,  
14     the reason that they did that study back in -- what  
15     was that -- when was the Hall study done?

16                    Anyway, the reason they did that study  
17     was because the medical examiner data was of good  
18     quality, and they did some of this validation and  
19     did not document any problem.

20            Q.     And you yourself have not conducted any of  
21     that type of data analysis, correct?

22            A.     No, I have relied on both those two -- the  
23     -- those two evaluations and they have determined  
24     to me -- it looked good to me, and there'd be no

1 change in procedures.

2 Q. What benchmarks did you use in order to  
3 determine whether that data was valid?

4 A. I do know that the forensic -- that the --  
5 that the forensic toxicology laboratory has been  
6 certified and accredited and has remained to be  
7 accredited, as far as I know. I haven't checked  
8 every single month of every single year to know  
9 that, but it has been documented as being an  
10 accredited laboratory.

11 Q. So you relied on the accreditation of the  
12 toxicology lab, correct?

13 MR. BURNETT: Objection.

14 A. I relied mostly on the opinion of the --  
15 Doctor Kraner, who is the top -- chief  
16 toxicologist.

17 Q. So you didn't create any reliability  
18 testing on your own, correct?

19 A. No, I've relied on the -- oh, we check --  
20 the data is regularly checked. If it doesn't make  
21 sense, we do go back to the medical examiner if we  
22 see something that doesn't make sense or if a drug  
23 level doesn't make sense, we go back and check and  
24 check whether there could have been a minor



1 extraction error.

2 Q. And have you personally done that in  
3 connection with forming your opinions in this case?

4 A. It hasn't altered my case, because my case  
5 relied on the Vital Statistics data which is the  
6 recording of the actual drugs on the death  
7 certificates.

8 Q. But you yourself have not conducted any  
9 reliability testing for the data that you've  
10 referenced in your report, correct?

11 MR. BURNETT: Objection.

12 A. In -- not -- we relied when we checked the  
13 data, and the Vital Statistics data is checked and  
14 double-checked by the people that do it, but we  
15 rely -- like most things, you can't check  
16 absolutely everything, and so we do rely on what's  
17 generally considered to have been a high-quality  
18 Vital Statistics program.

19 Q. And so you haven't checked that data  
20 personally, correct?

21 MR. BURNETT: Objection.

22 A. What do you mean by "checked?" At what  
23 level do you mean checking?

24 Q. Have you run -- have you tested the

1 reliability of the data personally? It's a "yes"  
2 or "no" question.

3 A. In terms of reliability, we do checks. If  
4 it doesn't make sense, or if it seems clearly  
5 errors, we would pick those up.

6 So I don't quite know at what level of  
7 checking that you mean. To the -- if you mean that  
8 I -- have I personally looked at every toxicology  
9 report in the state and looked at every death  
10 certificate to make sure that they wrote it down in  
11 exactly the right way and then went back and  
12 checked that every person entered the data in the  
13 same way, I have not.

14 Q. So let's try to make this more concrete.  
15 One of the major sources of data cited in your  
16 report is the data compiled by the West Virginia  
17 Office of the Chief Medical Examiner. Correct?

18 A. Yes.

19 Q. What, if anything, did you do to test the  
20 reliability of the data from the Office of the  
21 Chief Medical Examiner that you cited in your  
22 report?

23 A. I didn't cite anything in my report about  
24 that, checking that quality.

1 Q. Okay. Did you do anything to check the  
2 reliability of that data?

3 A. I relied on the discussions with the people  
4 doing the testing as to what our -- where the data  
5 comes from. But otherwise, no.

6 Q. Okay. So you relied on the Office of the  
7 Chief Medical Examiner in order to produce the data  
8 that you've relied on without checking it.  
9 Correct?

10 MR. BURNETT: Objection.

11 A. To the point that we check it to make sure  
12 that the data -- we do internal checks, but it's a  
13 matter of at what level you're checking. Is it  
14 every single spelling mistake when they write  
15 something down or whatever -- you can't check  
16 everything.

17 Q. At what level did you check the data  
18 provided by the Office of the Chief Medical  
19 Examiner?

20 A. If we see inconsistencies that don't make  
21 sense or a drug name that's written -- would be  
22 written down -- that actually would be done, I  
23 know, by the Vital Statistics office. Something  
24 that's written down as a wrong name or something

1     like that, that would be picked up.

2                     But I didn't check it, no.

3             Q.     Okay. You didn't check it yourself?

4             A.     That's correct.

5             Q.     Given the -- we've talked about toxicology  
6 screens, correct, Doctor?

7             A.     Yeah, we talked about doing toxicology  
8 testing, yes.

9             Q.     Can a medical examiner determine a cause of  
10 death on a toxicology screen alone?

11            A.     No. It's a process by looking at the  
12 toxicology results, looking at the autopsy result,  
13 and it's up to the -- the final decision that's  
14 made is the expert opinion of the medical examiner  
15 based on the preponderance -- as I understand the  
16 legal term, the preponderance of evidence presented  
17 to them, along which with they have toxicology, and  
18 they make a determination that if a drug was -- was  
19 found -- drug was responsible -- at least partially  
20 responsible for the death, they would include it on  
21 the death certificate, and then it would have been  
22 in the data that I used.

23            Q.     Doctor --

24            A.     Contributed --

1 Q. -- so --

2 A. The term they use is "contributed to the  
3 death." Whether that particular drug contributed  
4 to the death.

5 Q. Doctor, I'll represent to you that in the  
6 context of this case, Doctor Mock has testified  
7 that it would be irresponsible to claim to identify  
8 the cause and manner of death based on a toxicology  
9 screen. Do you agree with that statement?

10 A. I would agree definitely with that.

11 Q. More information beyond the toxicology  
12 screen is needed to determine the cause of death,  
13 correct?

14 A. Correct.

15 Q. For example, evidence from the place where  
16 a death occurred might be important. Correct?

17 A. Often is, yes.

18 Q. Drug paraphernalia at the scene of an  
19 overdose might be important to determining the  
20 cause of death, correct?

21 A. It can provide valuable evidence, yes.

22 Q. Other evidence such as illicit drugs at the  
23 scene of an overdose might also be important to  
24 determining the cause of the death, correct?

1           A.    Yes, that's used as part of their process,  
2    yes.

3           Q.    Photographs of the overdose scene could be  
4    important to determining the cause of death,  
5    correct?

6           A.    They can provide valuable supplemental  
7    information in some cases.

8           Q.    Those sources of supplemental information  
9    that we've just reviewed are collected by law  
10   enforcement rather than the medical examiner,  
11   correct?

12          A.    It's often done in collaboration together,  
13   as I understand it.

14          Q.    Is the medical -- to the best of your  
15   knowledge, is the medical examiner responsible for  
16   collecting those types of supplemental information  
17   that we've just discussed?

18          A.    I think a lot of it is done on a  
19   case-by-case basis if they feel it is needed.

20          Q.    Doctor, are you aware that the West  
21   Virginia State Crime Lab performed toxicology tests  
22   on evidence found at suspected -- on the scene of  
23   suspected drug overdoses?

24          A.    I would expect that they would do that,

1 yes. It's common procedure.

2 Q. Doctor, are you aware that the State Crime  
3 Lab has a significant backlog?

4 MR. BURNETT: Objection.

5 A. I'm not aware. I could understand it did.  
6 But that's not really relevant, because the data  
7 that I use comes from our medical examiner lab, and  
8 it's what's actually found inside the person as  
9 against what was found at the scene.

10 So none of that information is  
11 necessarily used.

12 Q. But as you said, you agree that toxicology  
13 results alone are insufficient to determine the  
14 cause of death, correct?

15 A. In most cases.

16 Q. Doctor, I'll represent to you that Doctor  
17 Mock has testified that in most instances, the  
18 medical examiner determines a cause of death before  
19 results from the State Crime Lab are available.  
20 Were you aware of that when you relied on the  
21 medical examiner data in order to form your  
22 opinion --

23 A. You know, I --

24 Q. Were you aware of that? "Yes" or "no,"

1 sir.

2 A. I wasn't aware of that, but it's not  
3 relevant. Because they have got the -- you could  
4 find a drug at the scene, but it might be a whole  
5 different drug to actually the drug that that  
6 particular person had consumed at the time and were  
7 responsible for killing them.

8 They're not necessary just because the  
9 drug -- one drug was found at the scene and tested.  
10 I don't see that as being that relevant to the  
11 toxicology that we actually find inside somebody  
12 when they die.

13 Q. But you weren't aware of that information,  
14 correct?

15 MR. BURNETT: Objection.

16 A. I wasn't aware of it, but I don't see the  
17 relevance.

18 Q. Doctor, your report assessed accidental  
19 poisonings, correct?

20 A. That's correct.

21 Q. So it excluded suicides from its analysis,  
22 correct?

23 A. Yes, correct.

24 Q. And differentiating between suicides and



1 accidental poisonings, you relied on the  
2 determinations of the medical examiner, correct?

3 A. That's correct.

4 Q. And as we just determined, the medical  
5 examiner did not have the benefit of law  
6 enforcement input prior to making most of its  
7 determinations, correct?

8 MR. BURNETT: Objection.

9 A. I think you would have to check on that  
10 with the medical examiner. I'm not -- in some --  
11 at times, they do, in my experience, but I don't  
12 know for sure with the West Virginia Medical  
13 Examiner.

14 Q. That's something that you don't know about,  
15 correct?

16 A. I don't know the full details. I could  
17 imagine that it's missing in some, but I don't  
18 know.

19 Q. Doctor, do you know the criteria that the  
20 West Virginia Medical Examiner's Office uses to  
21 distinguish between suicides and accidental  
22 poisonings?

23 A. There are some well-established guidelines  
24 that people use, but I -- I don't know their exact

1 criteria.

2 Q. And you didn't consider the criteria used  
3 by the medical examiner's office before relying on  
4 its data in forming your opinions in this case,  
5 correct?

6 A. What I would say is that the medical exam  
7 -- the distribution of -- I have looked in the past  
8 that suicides versus accidents, and in West  
9 Virginia - in common with most other places - the  
10 vast bulk of the drug poisoning deaths are  
11 considered to be accident -- are classified as  
12 accidental.

13 Q. Did you undertake any inquiry in order to  
14 determine the protocol that the West Virginia  
15 Office of the Chief Medical Examiner uses in order  
16 to classify suicide?

17 MR. BURNETT: Objection.

18 A. I did not, but the find -- but the  
19 reporting of the ratio of suicide to accident is  
20 very consistent with national standards, the ratio.

21 Q. But you didn't undertake any independent  
22 inquiry, correct?

23 A. No.

24 Q. Doctor, heroin can be difficult to detect

1 in fatal overdoses, correct?

2 A. Correct.

3 Q. Your report separately lists deaths related  
4 to heroin and deaths related to morphine, correct?

5 A. Yes. Well, it lists them out, yes,  
6 exactly.

7 Q. Doctor, heroin metabolizes into morphine,  
8 correct?

9 A. Yes.

10 Q. Heroin also metabolizes into another  
11 chemical, 6-monoacetylmorphine, correct?

12 A. Yes.

13 Q. And if I refer to 6-MAM, you'll know that  
14 I'm referring to 6-monoacetylmorphine because it's  
15 very difficult to say.

16 A. Yep.

17 Q. Correct?

18 A. Yep.

19 Q. Okay. Thank you, I appreciate that.

20 Doctor, both morphine and 6-MAM are present in the  
21 body when heroin is metabolized, correct?

22 A. Yes.

23 Q. Is there --

24 A. Sometimes you may not get each of them. As

1 I understand it, it's quite difficult to determine.

2 Q. Is that -- that's because 6-MAM is very  
3 difficult to identify in small amounts, correct?

4 A. I think that's the reason.

5 Q. If the West Virginia Office of the Chief  
6 Medical Examiner detects morphine by no 6-MAM, the  
7 office categorizes the death as related to morphine  
8 but not heroin, correct?

9 A. I'm not sure about that in every single  
10 case. As in our discussions with that, we've  
11 clearly -- there are difficulties in determining  
12 whether heroin was involved.

13 Q. And did you undertake any inquiry to  
14 determine the protocol pursuant to which the Office  
15 of the Chief Medical Examiner identifies heroin  
16 deaths?

17 A. We've had some discussion about that over  
18 the years with regard to papers and how to prevent  
19 it, and as I understand it, they are probably a  
20 little cautious about calling it a heroin if  
21 there's -- if they don't have any other evidence.

22 Q. And when you're --

23 A. Because sometimes you just find the  
24 morphine.

1 Q. And when you're talking about -- when you  
2 reference discussions, with whom did you have these  
3 discussions?

4 A. These would be in e-mail discussions and  
5 papers -- comments on papers as we're trying to  
6 write our paper and make sure that it's as  
7 scientifically as correct as possible.

8 Q. Are those conversations that you had with  
9 Doctor Mock?

10 A. I will say it wasn't with myself  
11 personally; it was with my colleague Maria Abate  
12 who would have been having most of the discussions  
13 about that. She's the pharmacist/toxicologist who  
14 is a part of our team.

15 Q. Okay. Doctor, the difficulty in  
16 identifying heroin as metabolized in overdose may  
17 result in an underreporting of heroin deaths,  
18 correct?

19 MR. BURNETT: Objection.

20 A. That -- there certainly is described in the  
21 literature that there can be underreporting of  
22 these deaths.

23 Q. And do you have any reason to disagree with  
24 the literature which reports an undercounting of

1 heroin deaths?

2 A. No, I don't.

3 Q. Doctor, do you still have Exhibit 3 handy?  
4 It's a copy of your report.

5 A. Yes, I do. It's in front of me.

6 Q. Okay. So if we turn to Exhibit A of your  
7 report, which follows right after page 18 of the  
8 numbered pages --

9 A. Got it.

10 Q. -- Exhibit A includes a list of deaths  
11 related to -- associated with drugs by year.  
12 Correct?

13 A. Yes.

14 Q. And if we look at the drugs included in  
15 your Exhibit A, we see that you included morphine  
16 as a category of drugs separate from heroin.  
17 Correct?

18 A. That's correct.

19 Q. Doctor, you didn't perform any independent  
20 assessment of the toxicology screens that formed  
21 the basis of your opinion, correct? That's what  
22 you said earlier.

23 A. No, but we --

24 MR. BURNETT: Objection.

1           A.     Yeah. Did not. But we had considerable  
2 discussion of the issues relating to the morphine  
3 and the heroin, and I think if you read our paper  
4 on this, it mentions that specifically.

5           Q.     Doctor, which paper are you referencing,  
6 just for clarity of the record?

7           A.     That was the fentanyl paper that we -- I  
8 talked about -- the "Fentanyl and fentanyl-analog  
9 involvement in drug-related deaths" that I cite in  
10 my report.

11          Q.     Thank you. Doctor, so if the medical  
12 examiner -- the West Virginia medical examiner,  
13 failed to detect small amounts of 6-MAM and  
14 erroneously categorized a heroin overdose as  
15 related to morphine, you wouldn't have identified  
16 that error in preparing Exhibit A. Correct?

17                   MR. BURNETT: Objection, calls for  
18 speculation.

19          A.     Yeah, I would not, and if you look at it,  
20 the heroin deaths exceed the morphine deaths quite  
21 considerably.

22          Q.     In the case that the chief medical examiner  
23 was unable to detect 6-MAM and categorized heroin  
24 deaths erroneously as a morphine death, that

1 categorization would carry through to the chart  
2 which you've presented as Exhibit A. Correct?

3 MR. BURNETT: Objection.

4 A. They possibly could do.

5 Q. And as it follows, Doctor, you would have  
6 categorized that erroneous morphine death as  
7 related to prescription opioids, correct?

8 MR. BURNETT: Objection.

9 A. Possibly. But I would have to look at the  
10 ratio -- yeah, the -- if you were to look at that,  
11 are you talking about the -- on page 11, the figure  
12 on page 11?

13 Q. Well, if we -- we can do that. So let's go  
14 to page 11 of your report, which is Exhibit 3. And  
15 I think, Doctor, you were calling out Figure 1. Do  
16 you have that in front of you?

17 A. Yep. Because if you look at it, the  
18 morphine deaths are about three times the overall  
19 -- more than three times the heroin. So even if  
20 you were to bring down some of those, you would  
21 only be, at best, bringing those figures up a very  
22 small -- a small amount.

23 You would bring them up by a third, if  
24 that was the case. Well, by about a quarter,



1 actually.

2 Q. So Doctor, let me ask a question. So we've  
3 now just turned to page 11 in your report, and  
4 we're looking together at Figure 1. If we look at  
5 your Figure 1, you'll see that morphine deaths are  
6 included in the red line that represents deaths  
7 from prescription opiates -- opioids from the  
8 period 2001 to 2011.

9 Do you see that?

10 A. That's correct.

11 Q. Doctor, you don't know how many deaths that  
12 were caused by heroin might have been incorrectly  
13 included in the count for morphine deaths, correct?

14 MR. BURNETT: Objection.

15 A. I do not know, but if you go back and look  
16 at the exhibit that you --

17 Q. You don't --

18 A. -- cited --

19 Q. You do not know. It -- Doctor, it's just a  
20 "yes" or "no" question. You don't -- you don't  
21 know, correct?

22 MR. BURNETT: Ms. Wu, you interrupted  
23 the witness. He was in the process of answering  
24 your question.

1 MS. WU: It was a "yes" or "no"  
2 question.

3 A. What we normally do in studies, we don't  
4 have "yes" or "no" answers. We have an error bar  
5 around it, so if you were to create an error bar  
6 around it to be able to estimate, you would find  
7 that overall, there were 330 heroins and there were  
8 108 morphine, and you probably could find -- and so  
9 at best, there would be only a third more, even if  
10 you were to bring all of the morphine down into the  
11 heroin, you would only go up about 25 percent.

12 So it would not greatly change the  
13 scope of those curves. And so that's what we would  
14 do in -- we're never 100 percent sure about --  
15 certainly with regard to the heroin.

16 But if it was, it would not  
17 dramatically change the shape of those curves.

18 Q. Okay.

19 A. It might change the actual number.

20 Q. Doctor, my question was more narrow than  
21 that. Doctor, you don't know how many deaths that  
22 were caused by heroin may have been incorrectly  
23 included in the number of deaths represented by the  
24 red line in Figure 1, correct?

1 MR. BURNETT: Objection, asked and  
2 answered.

3 A. Yeah. I do know that if -- that the -- the  
4 difference would be relatively small, but the  
5 extent to which, I do not know.

6 Q. Doctor, Figure 2 also has -- also on page  
7 11, Figure 2, has a red line that indicates the  
8 number of deaths associated with prescription  
9 opioids between 2001 and 2018. Do you see that?

10 A. Yes.

11 Q. Once again, fatal overdoses associated with  
12 morphine are included in the red line which shows  
13 prescription opioid overdose deaths. Correct?

14 A. Correct.

15 Q. Once again, Doctor, you don't know how many  
16 deaths caused by heroin were incorrectly reported  
17 as caused by morphine for the period 2001 to 2018?

18 MR. BURNETT: Objection.

19 A. No, I do not. I would say that there's a  
20 error -- and if I look at the data, actually, it's  
21 even a lessor proportion -- would have relatively  
22 less impact in recent years, looking at that.

23 Q. Doctor, any deaths caused by heroin that  
24 were incorrectly recorded as caused by morphine

1 would be shown as having been caused by a  
2 prescription opioid in Figure 2, correct?

3 A. The --

4 MR. BURNETT: Objection.

5 A. There might have been some  
6 misclassification, but the effect would be minimal.

7 Q. And that type -- that's the same type of  
8 miscategorization which you referenced in your 2019  
9 article, correct?

10 A. Correct.

11 Q. Doctor, I'd like to talk a little bit about  
12 fentanyl. In your report, you categorize fentanyl  
13 as a prescription opioid for the period 2001  
14 through 2011. Correct?

15 A. Yes, I think it was based on the C -- as we  
16 -- as I under -- the best source of that was the  
17 Centers for Disease Control, which if I remember  
18 correctly, stated that after a certain year - which  
19 I think is 2017 - that the vast bulk of the  
20 fentanyl was illicit at that period of time.

21 Q. And then you characterized fentanyl as an  
22 illicit opioid for the time period 2011 for {sic}  
23 2018, correct?

24 A. That's correct. And you can see that

1     there's very little in 2014. That was including  
2     all of them. Yes.

3           Q.     Now, if we look at Exhibit A to your  
4     report, which is Exhibit 3 --

5                     MR. BURNETT: Exhibit A?

6                     MS. WU: Yes, Exhibit A to the report  
7     which is Exhibit 3.

8           A.     Exhibit --

9                     MR. BURNETT: Yeah, right, right.

10                    THE DEPONENT: Is that the exhibit on  
11     my report, Exhibit A?

12                    MR. BURNETT: Yes, Exhibit A on your  
13     report which she has marked as Exhibit 3.

14           A.     Oh, good, yes.

15           Q.     Thank you, Doctor.

16                    MS. WU: Thank you, David.

17           Q.     So if we look at Exhibit A to your report,  
18     there was at least one death associated with  
19     fentanyl for each year, 2001 through 2011.  
20     Correct?

21           A.     Yes, that's correct.

22           Q.     And none of those deaths are categorized as  
23     associated with illicit opioids in your Figure 2,  
24     correct?

1 A. That's correct.

2 Q. But you didn't review the medical records  
3 for each of the individuals associated with those  
4 overdoses reported here, correct?

5 A. No. We re -- I relied on evidence from the  
6 literature as to when illicit fentanyl came into --  
7 started coming into widespread availability.

8 Q. Doctor, are you aware that the West  
9 Virginia Office of the Chief Medical Examiner did  
10 not consistently distinguish between prescription  
11 fentanyl and illicit fentanyl prior to 2010?

12 A. I would be aware of that. But as I  
13 understand the literature, does not docu -- and I  
14 think drug seizures probably -- basically the  
15 Centers for Disease Control has suggested in their  
16 literature that from 2013 on, the vast bulk of --  
17 that was the period that the dramatic increase in  
18 the availability of illicit heroin began.

19 Q. And so again, you don't know how the  
20 fentanyl deaths were reported in the medical  
21 examiner data on which you relied. Correct?

22 MR. BURNETT: Objection.

23 A. It's the same chemical. And I don't think  
24 -- other than looking for contaminants in it, it's

1 a drug -- it's a molecule, and it would be the same  
2 molecule. If it's called fentanyl, it would be the  
3 same drug, and there would be no way of  
4 distinguishing between them.

5 Q. And that would be how you would distinguish  
6 based on a toxicology screen alone, correct?

7 A. That's correct, you would best be relying  
8 on what molecule they find.

9 Q. And as Doctor Mock testified - and you  
10 agreed - it is improper to categorize a cause of  
11 death based on a toxicology screen alone. Correct?

12 MR. BURNETT: Objection.

13 A. I'm relying on his judgment. But it sounds  
14 like it.

15 Q. Okay.

16 MS. WU: So we've been going almost an  
17 hour, and I apologize. I've got to go get my power  
18 cord this time. Could we go off the record and  
19 just take ten minutes?

20 MR. BURNETT: Sure.

21 MS. WU: Take it now? Okay. Okay,  
22 so --

23 VIDEO OPERATOR: Going off the record.  
24 The time is 1:27 p.m.

1 (A recess was taken after which the  
2 proceedings continued as follows:)

3 VIDEO OPERATOR: Now begins Media Unit  
4 5 in the deposition of Gordon Smith. We're back on  
5 the record. The time is 1:54 p.m.

6 BY MS. WU:

7 Q. Doctor, we just took a brief break. You  
8 understand that you're still under oath, correct?

9 A. Correct. Yes.

10 Q. Before our break, we were talking about  
11 fentanyl, and I want to pick up where we left off.  
12 Do you have Exhibit 3, which is your report, in  
13 front of you?

14 A. Yes, I do.

15 Q. Doctor, if we turn to page 10 of your  
16 report, you state that "fentanyl overdoses began to  
17 rise steeply in 2015, with the growing presence of  
18 illicit fentanyl."

19 Do you see that?

20 A. Yes.

21 Q. What is the source for that statement?

22 A. Began to rise -- that is -- this is the  
23 Vital Statistics data, and that's what's shown on  
24 Figure 2 on page 11.



1 Q. And now if we look at your -- back a few  
2 pages to page 7 of your report -- I'm sorry, it's  
3 Footnote 7 on page 8 of your report. I apologize.

4 A. Yes.

5 Q. You cite CDC analysis -- and quote it. It  
6 says, "The third wave began in 2013, with  
7 significant increases in overdose deaths involving  
8 synthetic opioids," specifically, "those involving  
9 illicitly manufactured fentanyl." Do you see that?

10 A. Yes.

11 Q. So illicit fentanyl is listed as a problem  
12 as far back as 2013, correct?

13 A. At a national level. It took a little  
14 longer to come to West Virginia, yes.

15 Q. Do you have an opinion as to when illicit  
16 fentanyl first became available nationally?

17 A. I'm relying -- my opinion is based on what  
18 the Centers for Disease Control report, that felt  
19 that -- that this really became a problem in --  
20 beginning in 2013, and that their general  
21 understanding is that before that, they weren't  
22 bringing in the -- I guess the Chinese hadn't  
23 learned how to make it or whatever, but anyway,  
24 they created a market for it.

1 Q. Doctor, do you know if there were domestic  
2 sources for illicit fentanyl prior to 2013?

3 A. There were prescription as a source. There  
4 was a -- there was a patch, Duragesic patch, that  
5 was available.

6 Q. Was there illicitly -- I should say  
7 illicitly-manufactured fentanyl available in the  
8 United States prior to 2013?

9 A. Not that I know of in any quantity, based  
10 on the reports that I've seen.

11 Q. So Doctor, I'd like to show you another  
12 exhibit, Exhibit 15 --

13 MS. WU: And Counsel, we're going to  
14 do this one by screen share. We sent it last  
15 night. I'm not sure if you have hard copies with  
16 you.

17 MR. BURNETT: Yeah, I have the hard  
18 copy. Remind me what the name of the document is.

19 MS. WU: Sure. It's fentanyl briefing  
20 sheet for first responders.

21 MR. BURNETT: Yeah, okay.

22 MS. WU: We're also happy to put it up  
23 on the screen if that's helpful.

24 MR. BURNETT: Let's ask the witness.

1 This is -- so this is Exhibit 15. She sent this  
2 separate from the envelopes.

3 THE DEPONENT: Oh, okay. Yes. All  
4 right. Yes.

5 SMITH DEPOSITION EXHIBIT NO. 15

6 ("Fentanyl A Briefing Guide for First  
7 Responders" from the U.S. Department  
8 of Justice, Drug Enforcement  
9 Administration dated 6-6-17  
10 (HUNT\_01800002-021) was marked for  
11 identification purposes as Smith  
12 Deposition Exhibit No. 15.)

13 Q. Doctor, for the record, you're now looking  
14 at a document, Deposition Exhibit 15, which is  
15 titled Fentanyl briefing sheet for first  
16 responders. Do you have that in front of you?

17 A. Yes, I do.

18 Q. You didn't rely on this document in writing  
19 your report, correct?

20 A. No, I relied on the Centers for Disease  
21 Control document.

22 Q. Okay. Doctor, in looking at the document,  
23 you see it was prepared by the Drug Enforcement  
24 Administration, correct?

1 A. Correct, yes.

2 Q. And at the top of the first page of Exhibit  
3 15, someone has written "June 6th, 2017" by hand.  
4 Do you see that?

5 A. Correct. Yes, I do.

6 Q. In the bottom right, you see the word  
7 "HUNT," followed by a series of numbers. Do you  
8 see that?

9 A. Correct. The first page ends in 2. Yes.

10 Q. Okay. If I refer to that number as the  
11 Bates number, will you understand what I'm  
12 referring to? That's the Huntington production  
13 prefix, also known as a Bates number.

14 A. The Bate -- B-A-T-E-or --

15 Q. B-A-T-E, yes. Bates number.

16 A. Bates number. What's the origin of Bates?  
17 Is that the name of the person who did it?

18 Q. Very good question. Perhaps other counsel  
19 on the line can help me out here. I don't know.

20 MR. BURNETT: Yeah, I think there was  
21 a Mr. Bates that came up with the numbering system.  
22 It's used across --

23 THE DEPONENT: Oh, okay.

24 MR. BURNETT: -- in --

1 THE DEPONENT: Oh, okay. All  
2 government things? Oh, okay. Yes. Good.

3 Q. Okay. So if we turn to page 3 of the  
4 document which has the Bates stamp ending in a  
5 Number 5 in the bottom right-hand corner, do you  
6 see that?

7 A. Yes.

8 Q. Now, if we go to the paragraph that begins  
9 at the bottom of the left column of the page --

10 A. Yes.

11 Q. -- DEA report -- it reads, the DEA reports  
12 indicate that there were multiple clandestine labs  
13 producing illicit fentanyl in the U.S. between 2000  
14 and 2005.

15 Do you see that, Doctor?

16 A. Yes.

17 Q. You weren't aware of that when you produced  
18 your report, were you?

19 A. No, I wasn't.

20 Q. That's the same time frame when you have  
21 fentanyl listed as a prescription opioid in your  
22 report, correct?

23 A. That is correct.

24 Q. And between 2005 and 2007, according to

1 this report, law enforcement attributed more than  
2 1,000 deaths between Chicago and New Jersey to  
3 illicit fentanyl. You weren't aware of that when  
4 you prepared your report, correct?

5 A. No, I wasn't. I was much more aware of the  
6 statement at the bottom in the last -- in the  
7 second to the last paragraph. "Beginning in 2013,  
8 the DEA, along with" "law enforcement, began  
9 noticing an alarming" overdose -- "number of  
10 overdose incidents throughout the nations," and  
11 that's when they felt that it was illicit opioids.

12 But you're right. There seems to be  
13 some documentation prior to that.

14 Q. And West Virginia lies -- geographically  
15 lies between Chicago and New Jersey, correct?

16 A. Yes.

17 Q. If we turn to Exhibit A of your report,  
18 which is Deposition Exhibit 3 -- and look at the  
19 numbers for fentanyl.

20 A. Uh-huh.

21 Q. Your Exhibit A reports that there were 15  
22 deaths related to fentanyl in Cabell County between  
23 2005 and 2007. Correct?

24 A. Yes.

1 MR. BURNETT: You said 15 or 16?

2 Q. You attributed --

3 A. 2004, 2005 and 2006, is that what you're  
4 counting?

5 Q. 2005, 2006 and 2007.

6 A. Yes.

7 Q. 16.

8 A. 16, yes.

9 Q. I'm sorry. I said "15" before. So if we  
10 turn to Exhibit A of your report, it indicates --  
11 it reports that there were 16 deaths related to  
12 fentanyl in Cabell County between 2005 and 2007.  
13 Correct?

14 A. Correct.

15 Q. Doctor, you attributed each of those deaths  
16 to prescription fentanyl, correct?

17 A. Based on the CDC reports, that was correct.

18 Q. Doctor, you didn't consider the law  
19 enforcement reports such as the document marked as  
20 Exhibit 15 which report the prevalence of illicit  
21 fentanyl during that same time period, 2005 to  
22 2007. Correct?

23 MR. BURNETT: Objection,  
24 mischaracterizes the document.

1           A.     Yeah.  No, we did not, but we were not  
2     aware that it was much of a problem, and certainly  
3     the number of -- compared to the most recent time  
4     period where we do know that there were large  
5     amounts of illicit opioids and -- I'm not sure --

6                     People were -- certainly were dying  
7     from the prescribed patches, so I don't know.

8           Q.     But you didn't consider the law enforcement  
9     reports such as the DEA document identified as  
10    Exhibit 15 in preparing your report.  Correct?

11                    MR. BURNETT:  Objection.

12          A.     No.  And it says here that they closed --  
13    they started closing it down in 2005.  So those --

14          Q.     And Doctor --

15                    MR. BURNETT:  Wait.

16          Q.     Doctor, my question was --

17                    MR. BURNETT:  He was answering.

18          Q.     -- did you consider --

19                    MR. BURNETT:  He was --

20                    MS. WU:  Counsel, do you have an  
21    objection?  I don't have a question pending.

22          Q.     Doctor, my question was:  You did not  
23    consider law enforcement reports such as the DEA  
24    report marked as Deposition Exhibit 15 in preparing



1 your report in connection with this case, correct?

2 A. I did not have access to that report.

3 MR. BURNETT: Objection, asked and  
4 answered.

5 Q. Okay. So Doctor, earlier today, you  
6 mentioned the concept of polypharmacy. Could you  
7 explain for us what you mean when you use the term  
8 "polypharmacy"?

9 A. Polypharmacy is people taking more than one  
10 drug at the same time to get -- to get high off of  
11 their drug problem.

12 Q. Doctor, the presence of multiple drugs in  
13 toxicology screens can indicate polypharmacy,  
14 correct?

15 A. Correct.

16 Q. Polypharmacy is common among fatal  
17 overdoses in West Virginia, correct?

18 A. That's correct.

19 Q. More than three-quarters of fatal overdoses  
20 between 2005 and 2017 involved multiple drugs,  
21 correct?

22 A. I don't know which paper -- I presume  
23 that's from my report. Yes? I don't know the  
24 exact number.

1 Q. Doctor, you cited the Smith study for that  
2 proposition, correct?

3 A. Where was that, on which page was that?  
4 I'd have to remember.

5 Q. Well, let me try it in a simpler way.  
6 Doctor, do you agree that three-quarters of fatal  
7 drug overdoses in West Virginia for the period 2005  
8 to 2017 involve multiple drugs or polypharmacy?

9 A. That would be very consistent with our --  
10 our analyses of data.

11 Q. Doctor, when multiple drugs are present in  
12 a toxicology screen, each drug is included in the  
13 autopsy report, correct?

14 A. Only if in the opinion of the medical  
15 examiner that drug contributed to the death. For  
16 example --

17 Q. Are you aware --

18 A. -- if marijuana was found in the  
19 toxicology, they would not list it as having  
20 contributed to the death.

21 Q. Have you considered circumstances in which  
22 the West Virginia Office of the Chief Medical  
23 Examiner determined to exclude a drug identified in  
24 a toxicology screen from the autopsy report?

1           A.     Yes.   In discussions with them, if they  
2     found a very, very low level of a drug, they would  
3     not consider it -- they would find the drug, but  
4     they would not consider it as having contributed to  
5     the death, and therefore they would not write it on  
6     the death certificate.

7           Q.     And what is the source for your knowledge  
8     of that practice of the West Virginia Office of the  
9     Chief Medical Examiner?

10          A.     That's based on our correspondence and  
11     e-mails and correspondence with my colleague with  
12     the medical examiner as to how they determined  
13     whether they list the drug on the death certificate  
14     and whether they list it as having contributed to  
15     the death.

16          Q.     When you refer to "the medical examiner,"  
17     are you referring to Doctor Mock?

18          A.     Yes, Doctor Mock.   And also my colleague  
19     worked with the medical examiner prior to Doctor  
20     Mock.   I can't remember his name offhand.

21          Q.     Okay.   Did you work with any medical  
22     examiner other than Doctor Mock in West Virginia?

23          A.     No, I have not myself personally, but I  
24     know my colleague has.

1 Q. Doctor, there isn't a limit to the number  
2 of drugs that could be present on a toxicology  
3 screen, correct?

4 A. That's correct.

5 Q. In cases where multiple drugs are present  
6 in a toxicology screen, it may be difficult to  
7 determine which drug caused the death. Correct?

8 A. Exactly. That's why what they do is: They  
9 just list drugs that contrib -- they believe  
10 contributed to the death. If they didn't believe  
11 the drug contributed to the death, then they  
12 wouldn't list it.

13 Q. And more information beyond the toxicology  
14 screen results would be required to determine which  
15 drug actually caused the death. Correct?

16 A. For the drug -- and generally, as I  
17 understand it, for the drug to have contributed to  
18 the death, it would be based on the levels of the  
19 drug, that they were of a significant level.

20 So if they found just an absolute  
21 trace of morphine, for example, or a -- or a trace  
22 of OxyContin and no other -- no other symptom, then  
23 they would not consider that -- might not consider  
24 that drug to have contributed to the death.

1           Q.    So it's the general practice -- it is your  
2   understanding that it is the practice of the West  
3   Virginia Office of the Chief Medical Examiner to  
4   list each drug detected in a toxicology screen at  
5   more than a minimal level.   Correct?

6           A.    At more than a level that they considered  
7   to have contributed to the death.   And it's  
8   entirely up to the opinion of the medical examiner,  
9   and then when they have these team meetings to  
10   decide on difficult cases, which one -- which drugs  
11   they feel would have contributed.

12          Q.    And have you inquired into the standards  
13   that the medical examiner uses in order to  
14   determine when a drug detected in a toxicology  
15   screen is present in a substantial enough amount to  
16   have contributed -- to be listed as contributing to  
17   an overdose?

18          A.    I'm not sure.   The -- basically it's up --  
19   many of these things, it's a matter of the judgment  
20   based on the experience of a trained board  
21   certified pathologist who's gone through a standard  
22   training program, and I am not aware of every  
23   single criteria that they use.

24                   And it may even vary between trained

1 -- training programs as to how they consider it.

2 But I certainly know that if a insignificant amount  
3 of a drug were found, it would not be listed on the  
4 death signi -- death certificate.

5 Q. Doctor, based on your understanding of the  
6 practices of the Office of the Chief Medical  
7 Examiner in West Virginia, the fact that a drug is  
8 listed on an autopsy report does not mean that the  
9 medical examiner determined the drug caused the  
10 overdose death. Correct?

11 A. Yes. And I think I would make a  
12 distinction between the autopsy report, which is an  
13 individual report which might list all of the drugs  
14 that were found, as against the drugs that make it  
15 on to the death certificate on what they call "Part  
16 a" of the death certificate where they list the  
17 significant factors that contributed to the death.

18 So there may be a difference between  
19 the medical examiner report -- they could list --  
20 they may -- in the report, there may be the  
21 toxicology report that lists all the drugs they  
22 found, but then it is up to his certified -- his  
23 opinion as a professional to decide which of the  
24 drugs contributed to the death, and those are the

1 ones that are put on the death certificate, and  
2 they are the ones that make it into the Vital  
3 Statistics data that we've been using for this  
4 report.

5 Q. Okay. Let me reframe that with that  
6 clarification. So the fact that a drug is listed  
7 on "Part a" of a death certificate does not mean  
8 that the Office of the Chief Medical Examiner in  
9 West Virginia has found that the drug caused the  
10 overdose death.

11 A. They believe it contributed, and I -- it's  
12 very difficult to say what cause -- which inde --  
13 in polydrugs, the whole point of the polydrugs,  
14 there's never one drug that contributed.

15 For example, opioids depress the  
16 respiration and people stop breathing. So if you  
17 have three opioids, none of them alone may have a  
18 concentration enough to normally kill someone; but  
19 if you add the respiratory depressant to one drug  
20 to the respiratory depressant of the other opioid  
21 to the other opioid, then you can get enough  
22 respiratory depression to kill you.

23 Q. Doctor, you followed the practices of the  
24 Office of the Chief Medical Examiner and -- in the

1 way that you compiled the data in your report for  
2 polypharmacy overdose deaths, correct?

3 A. Yeah, we're relying on the data that we --  
4 that we get people to extract from their records,  
5 yes.

6 Q. So if multiple drugs were present on the  
7 toxicology screen of a decedent in West Virginia  
8 during the time frame covered in your report, that  
9 would count against the total for each of the drugs  
10 detected in the toxicology screen for that overdose  
11 event. Correct?

12 A. That's correct. The data -- and the data  
13 that's in the -- in that Exhibit A, they're not  
14 mutually exclusive, but because they can't --  
15 excuse me.

16 Q. Bless you.

17 A. -- that they -- it's almost impossible to  
18 determine which single drug caused it, but what's  
19 listed here are all of the drugs that they believe  
20 contributed.

21 And so they add up to more than the  
22 total number of overdose deaths.

23 Q. Doctor, according to Exhibit A of your  
24 report, which is Exhibit 3 -- I'm going to pause



1 for a second, sir.

2 A. That's okay.

3 Q. Okay. So do you have Exhibit 3 in front of  
4 you, Doctor?

5 A. Exhibit 3. Yes. Exhibit 3.

6 Q. So if we look at -- yes. Your -- the copy  
7 of your report.

8 A. My report, yes, I do, of course, I do, yes.

9 Q. And if we look at Exhibit A of your  
10 report --

11 A. Yep.

12 Q. -- I just want to make this more concrete  
13 by going through an example. If we look at the  
14 first year reported of 2001, there's a total of 16  
15 fatal overdoses reported, correct?

16 A. Yes, that's correct.

17 Q. And then if we go through the exercise of  
18 adding horizontally across the drugs attributed to  
19 each type of drug in the chart, we tally 32 deaths.  
20 Is that right?

21 A. I guess so, yes. That would -- that would  
22 make sense.

23 Q. And that's because - just to illustrate  
24 your point - that the counting -- the counting of

1 the drugs in a tox screen results in counting an  
2 overdose death into multiple categories. Correct?

3 A. That's correct, yes.

4 Q. Doctor, we were talking about fentanyl a  
5 short while ago. Do you recall that?

6 A. Yes.

7 Q. Doctor, you are aware that fentanyl is  
8 often mixed with other drugs, correct?

9 A. That's correct.

10 Q. Doctor, you -- would you agree that  
11 fentanyl can cause a fatal overdose at lower  
12 concentrations than other opioids?

13 A. Yes, it can.

14 Q. Doctor, you are also aware that the  
15 concentration of fentanyl can vary widely across  
16 different parts of the body in postmortem  
17 examinations, correct?

18 A. Yes.

19 Q. Most fatal overdoses related to fentanyl  
20 involved more than one drug. Correct?

21 A. That -- that's what we are finding, yes.

22 Q. And in addition to fentanyl, you are  
23 familiar with a number of fentanyl analogs,  
24 correct?

1 A. That's correct.

2 Q. Fentanyl analogs are examples of illicit  
3 fentanyl, correct?

4 A. Yes.

5 Q. Fentanyl analogs require specific chemical  
6 tests in order to identify them in a toxicology  
7 screen, correct?

8 A. Correct.

9 Q. If the examiner doesn't conduct one -- if  
10 the medical examiner doesn't conduct one of these  
11 tests, he could not identify fentanyl analogs,  
12 correct?

13 MR. BURNETT: Objection.

14 A. That -- if they didn't include the test for  
15 it, they wouldn't pick it up, yes.

16 Q. Doctor, do you know when the Office of the  
17 Chief Medical Examiner in West Virginia first  
18 implemented tests to identify fentanyl analogs?

19 A. I would have to go back and check my  
20 records. I am aware we -- that was something I  
21 remember we inquired about as to when it -- when  
22 they first started testing. And it's also a  
23 sequential thing, because they ask for individual  
24 tests here.

1 Q. You didn't take account of when those  
2 testing capacities became available to the Chief  
3 Medical Examiner's Office in West Virginia in  
4 connection with your report for this case, correct?

5 MR. BURNETT: Objection.

6 A. Not for this Exhibit A, we didn't, no.

7 Q. Okay. Do you know if those testing  
8 capabilities became available prior to 2001?

9 A. I do not know. As I say, I don't know the  
10 date, and I -- I've got it recorded somewhere in my  
11 office, but I don't know when.

12 Q. So Doctor, do you still have your report in  
13 front of you?

14 A. Yes, I do.

15 Q. So let's turn to page 8 of your report.

16 A. Yep.

17 Q. Doctor, in the first full paragraph on page  
18 8, it starts, "Among the individual drugs listed in  
19 Exhibit A, heroin has no legal use," it "is not  
20 prescribed, and is always illicit. The other  
21 drugs, including fentanyl, are sometimes prescribed  
22 but sometimes misused or used illicitly."

23 Do you see that?

24 A. Is it page 8?

1 Q. Yes.

2 A. Could you start off with the sentence again  
3 just to -- I was --

4 Q. Yes, certainly. I'm looking on your report  
5 on page 8, the first full paragraph on the page.

6 A. Yep.

7 Q. And reads, "Among the individual drugs  
8 listed" --

9 A. Yep, I know exactly where you are now.  
10 Yeah.

11 Q. -- "heroin has no legal use, is not  
12 prescribed and is always illicit. The other drugs,  
13 including fentanyl, are sometimes prescribed but  
14 sometimes misused or used illicitly."

15 Do you see that, Doctor?

16 A. Yes.

17 Q. So all of the drugs are sometimes  
18 prescribed but sometimes misused or used illicitly.  
19 Is that right?

20 A. Yes, I guess, yes.

21 Q. So now if we toggle back to Exhibit A which  
22 is referenced there --

23 I'll wait till we're together.

24 Are you at Exhibit A, Doctor?

1 A. Yes.

2 Q. So if we look at the second table on this  
3 -- I guess it's the lower half of the page on page  
4 1 of Exhibit A, do you see the column for cocaine  
5 overdose deaths?

6 A. Yes. Yes, cocaine, yes.

7 Q. Doctor, do you have any reason to believe  
8 that a single one of the individuals who died of a  
9 fatal overdose with cocaine in their system had a  
10 prescription for cocaine at the time they died?

11 MR. BURNETT: Objection.

12 A. I -- that was not subject to my  
13 investigation.

14 Q. Did you make any inquiry into the cocaine  
15 data which is listed in Exhibit A of your report?

16 A. With regard to what?

17 Q. With regard to the prescription drug  
18 histories for the individuals --

19 A. No, we did not --

20 Q. -- who overdosed --

21 A. -- examine prescription drug histories.

22 Q. Now, if we go over two columns and -- we  
23 see meth -- a column for methamphetamine. And I'm  
24 still looking at the same chart in Exhibit A. Do

1 you see that, Doctor?

2 A. Yes.

3 Q. Doctor, methamphetamine is a Schedule II  
4 controlled substance, correct?

5 A. Correct.

6 Q. Illicit methamphetamine is considered one  
7 of the most dangerous drug threats in the  
8 Appalachian drug -- Appalachian region today.  
9 Correct?

10 A. That's correct.

11 Q. Do you have any reason to believe that the  
12 overdose fatalities associated with methamphetamine  
13 in Exhibit A refer to prescribed methamphetamine?

14 A. I don't have any evidence of that.

15 Q. And you haven't investigated the origin of  
16 the methamphetamine associated with the overdoses  
17 listed on Exhibit A, correct?

18 A. I would reiterate, the way this data is  
19 collected, it's based on the chemical nature of the  
20 molecule of the drug and whether they were  
21 considered to be a prescribable drug, is probably  
22 the best way to think about it, and whether they  
23 were Schedule II or below.

24 And Schedule I drugs were generally

1 considered, for the vast bulk of this report, as  
2 being those that were illicit.

3 MR. BURNETT: Counsel, I don't mean to  
4 interrupt. When you have a good moment, I'd like  
5 to take a quick break.

6 MS. WU: Certainly. Let me just --  
7 I'm almost done with this. I'm happy to take a  
8 break.

9 BY MS. WU:

10 Q. Doctor, you didn't undertake any  
11 investigation into the origin of the  
12 methamphetamine, whether it be illicit or  
13 prescription methamphetamine associated with the  
14 overdose incidence reported in your Exhibit A,  
15 correct?

16 A. That was beyond the scope of my  
17 investigation.

18 Q. Doctor, just finally - and then we'll take  
19 a break - I'd like to call your attention to the  
20 last column, U-47700. Do you see that?

21 A. Yes.

22 Q. U-47700 is commonly referred to as pink  
23 heroin, correct?

24 A. I think so. I'm not sure of the popular



1 name for it. I'd have to look it up.

2 Q. Are you aware that U-47700 is a Schedule I  
3 drug?

4 A. I'm fairly sure it is. Or was --

5 Q. And that means --

6 A. Yep.

7 Q. I'm sorry, Doctor. I didn't mean to  
8 interrupt.

9 A. I presume so. Many of these synthetic  
10 drugs get scheduled as they get discovered.

11 Q. Okay. And a Schedule I drug has no  
12 FDA-approved medical purpose, correct?

13 A. Correct.

14 Q. Contrary to what we looked at in your  
15 report, heroin is not the only drug in this table  
16 that has no legal use and is always illicit,  
17 correct?

18 MR. BURNETT: Objection.

19 A. Yeah. The trouble is, it becomes legal  
20 when they discover it and when the DEA make it  
21 illegal, and it's a bit of a moving -- it's a bit  
22 of a moving target with drugs.

23 Q. You recognize that heroin is not the only  
24 illicit drug listed in your Exhibit A, correct?

1           A.     I guess so, yes.

2                   MS. WU:   Counsel, I'm happy to take a  
3 break now.   How long do you want to take?

4                   MR. BURNETT:   Yeah, let's take ten  
5 minutes.

6                   MS. WU:   Sure.

7                   MR. BURNETT:   Okay.

8                   VIDEO OPERATOR:   Going off the record.  
9 The time is 2:26 p.m.

10                   (A recess was taken after which the  
11 proceedings continued as follows:)

12                   VIDEO OPERATOR:   Now begins Media Unit  
13 6 in the deposition of Gordon Smith.   We're back on  
14 the record.   The time is 2:50 p.m.

15 BY MS. WU:

16           Q.     Doctor, we just took a break, a snack  
17 break, and now we're back on.   Do you understand  
18 that you're still under oath?

19           A.     Yes.

20           Q.     Thank you, Doctor.   Before the break, we  
21 spent some time talking about fentanyl, and I'd  
22 like to just close out that subject matter before  
23 moving on to new terrain.

24                   When you prepared your report, as you

1     said earlier, you did not consider the prescription  
2     drug histories for the individuals that fatally  
3     overdosed.    Correct?

4           A.     Not for the cases for the whole state, only  
5     looking at a couple of studies that had done that,  
6     yes.

7           Q.     So your report does not reflect work done  
8     in order to consider the prescription drug  
9     histories of the individuals who were involved in  
10    fatal overdose incidents, correct?

11          A.     Correct.

12          Q.     And if you had wanted to look at  
13    prescription drug histories, one way you could have  
14    done that was to look at the CSMP data available in  
15    West Virginia.   Correct?

16          A.     I could do -- I could have looked at that.  
17    It's difficult to get ahold of.

18          Q.     But in fact, you didn't look at the CSMP  
19    data, correct?

20          A.     Correct.

21          Q.     You also didn't undertake an exercise to  
22    look at the death certificates for the overdose  
23    fatalities reflected in the data in your report.  
24    Correct?

1           A.     And consistent with all of the studies that  
2     are done using death certificate data, I did not  
3     myself, and many, many studies that rely -- there's  
4     intensive checking on the Vital Statistics, so I  
5     did not feel it necessary.

6           Q.     For the overdose fatalities for which you  
7     identify prescription opioids, did you consider  
8     whether the prescription opioids detected in the  
9     toxicology report were used consistent with the  
10    physician's prescribing instructions?

11          A.     We did not examine that as part of my  
12    report.

13          Q.     Now, Counsel and Doctor, we're going to  
14    show a document which we're going to identify as  
15    Deposition Exhibit 16, and my colleague, Sam Howe,  
16    is going to help me put it up on the screen. So  
17    please bear with us.

18                   SMITH DEPOSITION EXHIBIT NO. 17

19                   (Copy of Amended WV Death Certificate  
20                   dated 1-22-09 (CCCLERK\_0009216) was  
21                   marked for identification purposes as  
22                   Smith Deposition Exhibit No. 17.)

23                   MS. WU: And for the record, this is a  
24    death certificate which is identified with the

1 Bates stamp CCCLERK\_0009216.

2 MR. BURNETT: Wait, sorry. Is this --  
3 do we have a paper copy of this?

4 MS. WU: No, you don't.

5 MR. BURNETT: Oh, you said this is 16.  
6 And the two paper copies you sent me were -- I  
7 thought they were 15 and 16.

8 MS. WU: Well, then to avoid confusion  
9 - thank you, Counsel - let's call this Deposition  
10 Exhibit 17. I apologize. My virtual exhibit  
11 tracking is lacking today.

12 So again, for the -- just for clarity  
13 in the record, we are now marking as Smith  
14 Deposition Exhibit No. 17 a death certificate which  
15 we have pulled up and it's identified with a Bates  
16 stamp CCCLERK\_0009216.

17 BY MS. WU:

18 Q. Doctor, can you see that on the screen in  
19 front of you?

20 A. Yeah, it was a little easier to read  
21 before. You had a bigger -- that's better.

22 Q. Here we go. Okay. Great. Can you read it  
23 okay now?

24 A. Yes.

1 Q. We are now looking at Deposition Exhibit  
2 No. 17, which is a copy of a death certificate. Do  
3 you see that?

4 A. Yes.

5 Q. And the location for the overdose is  
6 Huntington, West Virginia. Do you see that?

7 A. Yes.

8 Q. And the amended date of the death  
9 certificate stamped at the top is January 22, 2009.  
10 Do you see that?

11 A. Yes, I do.

12 Q. So this is a fatal overdose incident which  
13 would be reflected in the data reported in your  
14 expert report for this case. Correct?

15 MR. BURNETT: Objection.

16 A. Could you repeat that again? I didn't get  
17 --

18 Q. Doctor, we're now looking at a death  
19 certificate from 2009. Do you see that?

20 A. That's correct. Yes, I am looking at it.  
21 Yes.

22 Q. Fatal overdoses from 2009 are reflected in  
23 the overdose data reported in Exhibit 3, which is  
24 your expert report in this case. Correct?

1 A. Correct.

2 Q. Now, if we could scroll down -- and I want  
3 to give the witness a chance to review the  
4 document, so let's do this slowly. It's just a  
5 one-page document, so we don't have to rush.

6 If we could scroll down a little bit  
7 further, there is a section -- it's Section 27,  
8 Part 1. It says, "IMMEDIATE CAUSE (Final disease  
9 or condition resulting in death)."

10 Do you see that, Doctor?

11 A. Yes, I do.

12 Q. And it says, "Combined fentanyl and  
13 diazepam intoxication." Do you see that?

14 A. Correct, yes.

15 Q. Now, I'd like to go down a little bit  
16 further in the document. And I'm now looking at  
17 Box 29. It says, "MANNER OF DEATH." It says,  
18 "Accident." Do you see that?

19 A. Yes, I -- yes, yes, the check box, yes.

20 Q. And so an accidental death, again, would be  
21 included in the overdose -- the fatal overdose  
22 reports that are set forth in your report in this  
23 case, correct?

24 A. That's correct.

1           Q.    Now, if we follow that row across to Box 30  
2    -- 30D, it says, "DESCRIBE HOW INJURY OCCURRED."  
3    Do you see that, Doctor?

4           A.    Yes, I do.

5           Q.    And that box reads, "Ingested prescribed  
6    transdermal fentanyl patch." Do you see that?

7           A.    Correct.

8           Q.    Doctor, ingesting a fentanyl patch is  
9    inconsistent with the medical use of that product.  
10   Correct?

11          A.    It's not the normal way to use, yes, that's  
12   correct.

13          Q.    Are you aware of any situation in which a  
14   fentanyl patch has been prescribed for ingestion?

15          A.    Not that I'm aware of.

16          Q.    Are you aware of an FDA approval for a  
17   fentanyl patch for ingestion?

18          A.    I don't think it's an approved mode of use.

19          Q.    Are you -- can you identify any conduct of  
20   distributor defendants in this case that could have  
21   prevented the death reflected in Exhibit 17, which  
22   is -- was caused by an ingested fentanyl patch?

23                   MR. BURNETT: Objection, calls for  
24   speculation.



1           A.    Yes, I don't know. I can't see any --  
2           there's no name of anybody, distributor, on the  
3           death certificate.

4           Q.    Is there anything any distributor could  
5           have done to stop an individual from eating a  
6           prescribed fentanyl patch?

7                   MR. BURNETT: Objection. Calls for  
8           speculation.

9           A.    I don't know. I think it's purely  
10          speculation. There may be some theoretical thing  
11          they could have done, but I don't know.

12          Q.    As a prescribing physician, Doctor, would  
13          you foresee that an individual prescribed a  
14          fentanyl patch would eat it?

15          A.    The only -- it would depend if I knew the  
16          person was an addict, there could be some under --  
17          there could -- we might get concerned about that.

18                   But there's nothing reflected on the  
19          death certificate to indicate that.

20          Q.    That type of patient evaluation is specific  
21          to the province of the prescribing physician,  
22          correct?

23          A.    Generally, yes.

24          Q.    Because the prescribing physician is

1 uniquely able to weigh the risks and benefits of a  
2 prescription medication, correct?

3 MR. BURNETT: Objection.

4 A. Maybe that's standard practice, but it  
5 wasn't part of what I was called upon to examine.

6 Q. In your -- in your view as a prescribing  
7 physician yourself, do you agree that the  
8 prescribing physician is best positioned to  
9 evaluate the risks and benefits of a prescription  
10 medication?

11 A. That's standard medical practice.

12 Q. So you agree that the physician is in the  
13 best position to weigh the risks and benefits of a  
14 prescription medication. Correct?

15 MR. BURNETT: Objection, asked and  
16 answered.

17 THE DEPONENT: What's asked and --

18 MR. BURNETT: You can answer.

19 THE DEPONENT: Can answer this?

20 A. I would say probably so, yes.

21 Q. And addiction may be a risk of certain  
22 prescription medications, correct?

23 A. It can be. It is.

24 Q. Distributors such as McKesson are not able

1 to evaluate a patient's risk of addiction, correct?

2 MR. BURNETT: Objection.

3 A. They -- they don't have any -- they don't  
4 provide medications to individual patients; they  
5 provide them to the pharmacy.

6 Q. So they don't have the -- distributors do  
7 not have the opportunity to assess the addiction  
8 profile of a patient receiving prescription  
9 opioids, correct?

10 MR. BURNETT: Objection.

11 A. It's individual patients, but they -- no,  
12 they don't.

13 Q. Thank you, Doctor.

14 MS. WU: And Sam, thank you. We can  
15 take down the Exhibit 17.

16 Q. Okay, Doctor, I'm now going to leave  
17 fentanyl and move on to another subject. Doctor,  
18 state and local officials in West Virginia have  
19 worked for years to decrease the abuse of opioids,  
20 correct?

21 A. That's what I understand.

22 Q. Do you think that those efforts of the  
23 state and local communities have been effective?

24 MR. BURNETT: Objection.

1           A.    I think it's such a difficult problem. In  
2   some hand, yes; in some ways, no.

3           Q.    In what ways do you believe that West  
4   Virginia has been successful in decreasing the  
5   abuse of opioids?

6                   MR. BURNETT: Objection.

7           A.    It was not a subject of my investigation.  
8   I don't know -- my report.

9           Q.    A few moments ago, Doctor, you said that  
10   you believe in some ways, West Virginia has been  
11   successful in decreasing abuse of opioids.  
12   Correct?

13          A.    I'm looking -- based on the report and my  
14   data, I would see that in recent years, this -- in  
15   the most recent year, there's been a decrease in  
16   fatalities. So to that extent, I can testify on  
17   that, that there seems to have been.

18          Q.    To what do you attribute the decrease in  
19   overdose fatalities that you've identify in the  
20   data?

21                   MR. BURNETT: Objection, calls for  
22   speculation.

23          A.    Yes, there's no data to -- in my report  
24   that has any indication of that. But based on

1 reports in the literature, the general feeling is  
2 that provision of better treatment services and  
3 naloxone and Emergency Medical Services has been  
4 responsible for declining in its fatality. But  
5 that's not based on --

6 Q. Doctor, is -- Doctor, the data which you  
7 cite in your report reflects that abuse of  
8 prescription opioids has declined significantly.  
9 Correct?

10 MR. BURNETT: Objection.

11 A. I didn't do a significance test on it,  
12 statistical significance. But if you look at my  
13 figure, there certainly has been a decline in the  
14 last year.

15 Q. And the same is true for the abuse of  
16 heroin and fentanyl, correct?

17 A. They all declined together, as represented  
18 in the fatalities.

19 Q. If we look at Exhibit A to your report,  
20 which is Deposition Exhibit 3, if we look at the  
21 top chart and look at 2017, we see that there were  
22 184 total opioid-related overdose deaths as  
23 reported in Exhibit A. Do you see that?

24 A. Yes.

1 Q. And then if we go down just one line to  
2 Figure 2018, we see that there were 134  
3 opioid-related overdose deaths as recorded in your  
4 Exhibit A. Do you see that?

5 A. Yes. And in my report, I do note that the  
6 data for 2018 were not necessarily completely  
7 closed. Sometimes it takes time for the deaths to  
8 be closed.

9 Q. Doctor, for the data as reported in your  
10 Exhibit A, it reflects approximately a 27 percent  
11 decrease in opioid-related overdose deaths for the  
12 period 2017 to 2018. Correct?

13 A. That's correct.

14 MR. BURNETT: Objection.

15 Q. Doctor, the West Virginia Department of  
16 Health and Human Resources has not yet released its  
17 2019 overdose statistics, correct?

18 A. To the best of my knowledge. I haven't  
19 checked re -- checked recently.

20 Q. Are you aware that media reports suggest  
21 that the total number of fatal overdoses in Cabell  
22 County declined again in 2019?

23 A. I'm not sure. I haven't read the report --  
24 any reports.

1 Q. And you did not include any data from 2019,  
2 including preliminary data, in your report.

3 Correct?

4 A. That's correct, for exactly the reason you  
5 stated, that the data has not been finalized and  
6 it's not been made available.

7 Q. And the data would be maintained by the  
8 West Virginia Department of Health and Human  
9 Resources, correct?

10 A. That's correct.

11 Q. Now, do you have your report in front of  
12 you still, Doctor?

13 A. Yes, I do.

14 Q. Could we go to page 6 of your report? And  
15 page 6 of your report states that -- states, "I  
16 have accessed" -- I'm sorry. You note that you  
17 worked closely with the State Department of Health  
18 and Human Resources. Do you see that?

19 A. Yes.

20 Q. And then you go on to say, "I have access  
21 to detailed state Vital Statistics overdose  
22 fatality data for West Virginia from 2001 onwards."

23 Do you see that?

24 A. That's correct.

1 Q. A few sentences later, you continue: "This  
2 database is maintained by the Health Statistics  
3 Center" "and is continually updated." Correct?

4 A. Yes.

5 Q. You were referring to data that is not  
6 publicly available, correct?

7 A. Correct, yes.

8 Q. "Continually updated" as used in your  
9 report, implies that the data available in the  
10 system is more current than the data that has been  
11 periodically released to the public. Correct?

12 A. My guess is that the date they release the  
13 data to the public, the data that they have on hand  
14 was current. That's the way I understand it. And  
15 then after they release it, there may be other  
16 deaths that are cleared by the medical examiner and  
17 they -- then they update the numbers.

18 Q. To the best of your knowledge, Doctor, does  
19 the state currently have data available for 2019  
20 which has not been released to the public?

21 A. They may have it internally, but they also  
22 don't release it to investigators like myself until  
23 they feel confident that -- that they have reached  
24 -- it's a reasonable -- and they may issue a



1 preliminary, like as the data that I noticed up to  
2 2018 was not necessarily the final number, but  
3 there are often cases that dribble into their  
4 system, and with the very high overdose rates, the  
5 system has been a bit overwhelmed.

6 Q. What efforts, if any, did you undertake in  
7 order to obtain fatal overdose data from 2019?

8 MR. BURNETT: Objection.

9 A. At the time of my report, I was advised  
10 that it would -- this was the most recent data  
11 available.

12 Q. Who advised you of that?

13 A. A colleague of mine who work -- in the  
14 Vital -- in a series of e-mails from the Vital  
15 Statistics department.

16 Q. Cabell County is one of the plaintiffs in  
17 this lawsuit, correct?

18 A. Correct.

19 Q. Did you make any inquiry as to your clients  
20 in this case as to whether or not it could provide  
21 you with fatal overdose data for the year 2019?

22 A. I did not, because it's not my -- it's not  
23 my -- my understanding is that the data is all kept  
24 centrally and -- with respect to the fatalities and

1 they're unlikely to have it.

2 Q. You are not aware of any overdose  
3 information maintained by Cabell County, correct?

4 MR. BURNETT: Objection.

5 A. Often the local jurisdictions do keep track  
6 themselves of the ones they know of.

7 Q. What inquiry, if any, did you make to  
8 Cabell County in order to obtain overdose data for  
9 2019?

10 MR. BURNETT: Objection, asked and  
11 answered.

12 A. I did not do that.

13 Q. Now, earlier, Doctor, you stated that you  
14 are directing the West Virginia SUPPORT Needs  
15 Assessment. Do you recall that?

16 A. Correct.

17 Q. You wrote in your report that the SUPPORT  
18 project is funded by the Federal Centers for  
19 Medicare and Medicaid Services. Correct?

20 A. Correct.

21 Q. Do you anticipate that any services will be  
22 provided to Cabell County in connection with the  
23 SUPPORT project?

24 A. The SUPPORT project itself may not, but it

1 will be used to plan central allocation of services  
2 by the State Department of Health and Human  
3 Services.

4 Q. What type of services will the state  
5 provide as an outgrowth of the SUPPORT project?

6 A. The state funds programs for prevention.  
7 The exact detail, I'm not 100 percent sure of. But  
8 they provide funding for people to get treatment.

9 They provide grants to programs such  
10 as the QRT program that go out and investigate  
11 overdose deaths -- or over -- nonfatal overdoses,  
12 and then enroll and get people into treatment.

13 They fund prevention activities in the  
14 schools.

15 They fund a cross-section of  
16 activities to provide services for the treatment of  
17 opioid addiction.

18 Q. Do you know what -- over what period of  
19 time those services would be available to  
20 communities in West Virginia?

21 A. They're constantly -- the state gets  
22 prevention grants on an annual basis to the state,  
23 so the services are always available, but they're  
24 constrained by the amount of money that's

1 available.

2 Q. Doctor, your report includes data  
3 identifying the number of fatal overdoses  
4 associated with a variety of drugs in Cabell County  
5 between 2001 and 2018. Correct?

6 A. Correct.

7 Q. You did not review the underlying death  
8 certificates for those fatal overdoses, correct?

9 MR. BURNETT: Objection, asked and  
10 answered.

11 A. I think I answered that earlier by stating  
12 that the vast bulk of people doing analyses and  
13 death certificate data rely on the quality that we  
14 know that they -- that is done by Vital Statistics,  
15 and that's standard procedure.

16 MS. WU: Counsel, my earlier question  
17 was for the general West Virginia data which was  
18 studied in the report. I want to make sure it's  
19 the same for Cabell County.

20 Q. So Doctor, did you review death  
21 certificates associated with the data reported --  
22 that you have reported for fatal overdoses in  
23 Cabell County?

24 MR. BURNETT: I believe he just

1 answered that.

2 A. My answer is the same, that we would just  
3 rely - as would everybody, all the other  
4 researchers and program, public policy people -  
5 rely on the data provided by the Vital Statistics  
6 office.

7 Q. So the answer is no, you did not review  
8 death certificates, correct?

9 MR. BURNETT: Objection.

10 A. I did not.

11 Q. And for the fatal overdoses in Cabell  
12 County, you also did not review records in order to  
13 identify which decedents had valid prescriptions  
14 for opioids. Correct?

15 MR. BURNETT: Objection.

16 A. As I answered earlier, yes, I did not.

17 Q. And Doctor, selling or giving away  
18 prescription drugs - other than by a prescriber  
19 with a prescription - is one form of diversion,  
20 correct?

21 MR. BURNETT: Objection.

22 A. As I understand, I'm -- it depends on  
23 whether it's illegal, and I explained earlier that  
24 I was not sure whether it was legal or not.

1 Q. Do you know if stealing drugs is a form of  
2 criminal diversion?

3 A. I would assume it's a criminal offense.

4 Q. Are you aware that local and federal law  
5 enforcement officials who have testified in this  
6 case have provided testimony that all types of  
7 diversion are crimes?

8 MR. BURNETT: Objection.

9 A. I'm not aware of that.

10 Q. And your report did not take into account  
11 criminal activity by the decedent, correct?

12 A. My report was based on the finding of drugs  
13 that were considered to be prescription in Schedule  
14 II and below, and the illicit drugs that I  
15 considered for my report were both to be considered  
16 to be in Schedule I of the DEA.

17 Q. Okay. So now I'd like to ask you: Do you  
18 have your report in front of you still, Doctor?

19 A. Yes.

20 Q. I'd like to ask you to turn to Exhibit C?

21 MR. BURNETT: Exhibit C?

22 MS. WU: Yes.

23 Q. Do you see that, Doctor?

24 A. Yes.

1 Q. Exhibit C is a document which you  
2 incorporate into your report, the "West Virginia  
3 Drug Overdose Death Historical Overview for 2001"  
4 to "2015." Do you see that?

5 A. Yes, I do.

6 Q. Now, Doctor, I'd like to ask you to turn to  
7 page 19 of Exhibit C. Do you see that, Doctor?

8 A. Yes, I do.

9 Q. Now, I'd like to ask you to look at Figure  
10 31 in the middle of the page.

11 A. I can see that, yes.

12 Q. Do you see that?

13 A. Yes.

14 Q. And in the narrative accompanying Figure  
15 31, it says, "Figure 31 shows that 192 amphetamine-  
16 related deaths were detected from 2001 through  
17 2015, with 74% of the overdose deaths occurring in  
18 the last three years, 2013" to "2015."

19 Do you see that?

20 A. Yes, I do.

21 Q. And in your report, you stated that meth --  
22 that amphetamine was not recorded during that  
23 period. Is that correct?

24 A. I would have to go back and just check 100

1 percent.

2 MR. BURNETT: Take the time you need  
3 to find it.

4 A. Yea. 2017.

5 Q. I'm happy to expedite this if you'd like to  
6 look at your report, Doctor --

7 A. I have on record that they stopped  
8 reporting in 2012, and I would need to go back and  
9 discover why they stopped reporting on that then.

10 Q. So if I can direct your attention --

11 A. Some special study they did, but it -- it  
12 wasn't in the data that was given to me.

13 Q. So I'd like to call your attention, Doctor,  
14 to Exhibit A to your report, which is Deposition  
15 Exhibit No. 3. Do you have that, Doctor?

16 A. Exhibit A.

17 Q. To your report, which is Deposition Exhibit  
18 3.

19 A. Yes, I do. Yes.

20 Q. If we look at the second page, Note 1 to  
21 Exhibit A reads, "amphetamine was stopped reporting  
22 in the year 2012." Correct?

23 A. Yes, that's correct.

24 Q. Based on our review of Exhibit C to your



1 report - which is incorporated into your report -  
2 the state was in fact tracking amphetamine during  
3 that period, correct? 2012 forward.

4 A. In exhibit -- which exhibit?

5 Q. Exhibit C to your report.

6 A. Oh, it does seem -- does seem so, yes.  
7 Now, that, I do not know, and I would need to  
8 investigate that further.

9 Q. So Doctor, Note 1 to Exhibit A to your  
10 report is inaccurate, correct?

11 A. I would not say -- may have been some  
12 reason as to why it was not reported, and that  
13 would require further investigation.

14 Q. Doctor, do you agree that Exhibit C to your  
15 report includes state data for methamphetamine for  
16 the period that post-dates 2012?

17 A. If you -- sorry, let me just look at that.  
18 Yeah, I recorded that -- and the cases that get  
19 reported here are for the whole state anyway, but I  
20 don't know. I will have to investigate that  
21 further.

22 Q. Doctor, are you aware of any other  
23 inaccuracies in Exhibit A to your report?

24 MR. BURNETT: Objection. Misstates

1 his testimony.

2 THE DEPONENT: Yeah.

3 MR. BURNETT: You can answer.

4 A. No, I'm not aware of any other problems.

5 Q. Are you aware of any other data that you  
6 failed to consider in assembling Exhibit A, or your  
7 report, more broadly?

8 MR. BURNETT: Objection.

9 A. No, I was aware of the data that was  
10 provided -- this is the way the data was provided  
11 to me by the Vital Statistics office.

12 Q. Doctor, are you aware based on press  
13 reports or other data sources that methamphetamine  
14 is considered the greatest threat in terms of drugs  
15 used in the Appalachia region?

16 A. It certainly --

17 MR. BURNETT: Objection.

18 A. -- has become an increasing threat.

19 Q. Do you take account of that information in  
20 assembling your report for this case?

21 MR. BURNETT: Objection.

22 A. Yes, but it's quite clear that we include  
23 the methamphetamine data in our report.

24 Q. But according to your Exhibit A, it

1 misstates that methamphetamine data is not  
2 available for the period following 2012, correct?

3 MR. BURNETT: Objection, misstates the  
4 testimony.

5 A. I just stated that the amphetamine was  
6 stopped reporting. That was the footnote to the  
7 table that I was provided by Vital Statistics.

8 Q. And what work, if any, did you do to test  
9 the data provided to you by Vital Statistics?

10 MR. BURNETT: Objection, asked and  
11 answered.

12 A. I think I answered that earlier. We relied  
13 on the data they provide, they are considered to be  
14 reliable, widely used by people and standardly used  
15 in the reports and research.

16 Q. Did you check it against the data reported  
17 in your Exhibit C, the West Virginia Drug Overdose  
18 Deaths Historical Overview?

19 A. I did not check it against that report.

20 Q. Doctor, you're aware that --

21 A. I was using the same source.

22 Q. I'm sorry. Doctor, what did you mean by  
23 "the same source?" I'm sorry, I might have missed  
24 what you said.

1           A.     I'm sorry. It comes from the same database  
2     in the Vital Statistics office.

3           Q.     Doctor, I'd like to return to some of our  
4     discussion that we had earlier about drug  
5     trafficking organizations and criminal enterprises.  
6     Doctor, were you aware that local law enforcement  
7     in the City of Huntington and Cabell had identified  
8     drug trafficking organizations based in Detroit  
9     that were engaged in trafficking prescription  
10    opioids in Cabell County in the mid 2000s?

11                   MR. BURNETT: Objection, beyond the  
12    scope.

13           A.     Yeah, it was not something that I examined  
14    for my report.

15           Q.     Same question for detection of criminal  
16    organizations trafficking prescription opioids from  
17    Columbus, Ohio. Were you aware of that, Doctor?

18           A.     No, the type -- my report was based just on  
19    the drug chemicals found in dead people when they  
20    died.

21                   MR. BURNETT: And I'll lodge an  
22    objection, and just a reminder, Doctor Smith,  
23    again, give a pause for me to object, okay?

24                   THE DEPONENT: Certainly.

1           Q.    You didn't review any law enforcement  
2   reporting from the period 2001 to 2018 regarding  
3   the trafficking of prescription opioids into Cabell  
4   County, correct?

5                   MR. BURNETT:  Objection.

6           A.    It was not the subject of my investigation  
7   for my report.

8           Q.    So you didn't undertake that work, correct?

9           A.    That's correct.

10          Q.    And you didn't attempt to determine which  
11   of the fatal overdoses reflected in your report  
12   resulted from diverted prescription opioids,  
13   correct?

14                   MR. BURNETT:  Objection, asked and  
15   answered.

16          A.    To me, the most important -- my entire  
17   report is based on finding the chemical,  
18   irregardless of -- basically identifying what  
19   chemicals, what molecules were consumed by the  
20   people that died.

21          Q.    And the origin of the drugs consumed is not  
22   reported in your opinions, correct?

23                   MR. BURNETT:  Objection.

24          A.    It was not the subject of my report.

1 Q. And the origin of the report is not  
2 reflected in your opinions for this case, correct?

3 MR. BURNETT: Objection.

4 A. I don't quite understand what you're --  
5 what you're --

6 Q. Let me try that again. The origin of the  
7 drugs involved in the fatal overdoses are not part  
8 of your opinions in this case, correct?

9 A. That's correct.

10 Q. And therefore, it follows that any drugs  
11 distributed by the defendants in this case have not  
12 been analyzed as part of your opinions in this  
13 case. Correct?

14 A. I --

15 MR. BURNETT: Objection.

16 A. I would say that these drugs are all drugs  
17 that are prescription, and the only way they would  
18 have got in -- other than the counterfeit drugs  
19 coming in with fentanyl, the only way they would  
20 have got into the state is by having been brought  
21 in by somebody.

22 Q. Are you aware --

23 A. -- and it doesn't matter how they were  
24 brought in or not.

1 Q. Are you aware of pharmaceutical  
2 distributors other than McKesson, AmerisourceBergen  
3 and Cardinal?

4 A. I am not familiar -- very familiar with who  
5 -- what drug distributors there are in West  
6 Virginia.

7 Q. And you have not considered whether any of  
8 the substances identified in the toxicology screens  
9 you've referenced can be traced back to McKesson,  
10 Cardinal or AmerisourceBergen, correct?

11 MR. BURNETT: Objection, asked and  
12 answered.

13 A. Yeah, as stated, that was not the subject  
14 of my report and my investigation.

15 Q. You haven't done that work, correct?

16 MR. BURNETT: Objection.

17 A. It was not the subject of my investigation.

18 Q. And the toxicology data on which you relied  
19 would not allow you to undertake that exercise,  
20 correct?

21 A. The toxicology is based entirely on the  
22 molecules found and does not indicate the origin of  
23 the -- of the molecules and where they came from.

24 Q. Doctor, earlier, you referenced the Hall

1 study from 2008 which reviewed fatal overdoses in  
2 West Virginia. Do you recall that?

3 A. Yes, I do.

4 Q. And you also referred to a 2017 study, the  
5 Sanders study, correct?

6 A. Yes, correct.

7 Q. Neither the Hall study nor the Sanders  
8 study broke down their findings by county, correct?

9 A. Not that I know of. I would have to go  
10 back and look at the -- I certainly know the Hall  
11 one didn't, and I'm not sure whether there was  
12 mention of county in the Sanders study.

13 Q. The findings in the Hall and Sanders  
14 studies are statewide, correct?

15 MR. BURNETT: Objection.

16 A. As I understand it, the bulk of it would be  
17 statewide. There may be some mention of county  
18 data, but I don't remember.

19 Q. Doctor, are you familiar with the High  
20 Intensity Drug Trafficking program, also referred  
21 to as HIDTA?

22 A. Yes, I am.

23 Q. In preparing your report, do you consider  
24 that HIDTA has determined that the rates of drug



1 abuse in Cabell County are higher than elsewhere in  
2 West Virginia?

3 A. I've read several HIDTA reports. The  
4 earliest one that I read, they were most concerned  
5 about marijuana rather than opioids or other  
6 concerns back in the very early investigations, and  
7 then they became concerned about opioids.

8 Q. I think I've lost Doctor Smith.

9 A. I'm sorry, I just accidentally pulled out.  
10 I put my foot on the cord. I'm sorry.

11 Q. No problem.

12 A. Get back -- there we go. Good.

13 Q. Great. I can see you. Can you see me as  
14 well, Doctor?

15 A. Yep, I can see fine.

16 Q. Wonderful. Okay. So a moment ago, we were  
17 talking about HIDTA, and you referenced reviewing a  
18 number of HIDTA reports. Did you review those  
19 HIDTA reports in connection with your work for this  
20 case?

21 A. I looked up -- I was given a report from  
22 Hollister, and I did look at one of the reports  
23 that he cited, and the one that he cited documented  
24 that marijuana was the majority of the problem back

1 in the earlier times when they first started  
2 there --

3 Q. Are those reports that you've just  
4 referenced including -- included in the materials  
5 considered for your report?

6 A. No, I have reviewed those after my report  
7 was written.

8 Q. How --

9 A. -- not relevant to the case of my report.

10 Q. You don't plan to rely on those HIDTA  
11 reports in any way?

12 A. They are not part of my report, and so I  
13 won't be reporting on them.

14 Q. But you did consider them in connection  
15 with your report in this case, correct?

16 MR. BURNETT: Objection.

17 A. The reason I looked at them is because I  
18 saw the report from Hollister, and so as a good  
19 scientist, I decided to check on the references,  
20 and that's where I discovered that the concern that  
21 was quoted initially was actually regarding  
22 marijuana.

23 Q. You reference Hollister. Are you referring  
24 to a report by Larry Holifield?

1 A. Yes, Holifield, I apologize. Holifield.

2 Q. Larry Holifield is an expert retained by  
3 defendants in this case. Are you aware of that?

4 A. Yes.

5 Q. You reviewed Mr. Holifield's report, expert  
6 report, in this case?

7 A. Correct.

8 Q. Are you relying on your review of that  
9 report in connection with your opinions in this  
10 case?

11 MR. BURNETT: Objection.

12 A. It was not -- was not at all relative to  
13 the opinions. I did not have access to it when I  
14 wrote my opinions for this report, and my opinions  
15 are restricted to the report.

16 Q. What other expert reports have you been  
17 provided by counsel?

18 A. I saw a draft of the Keyes report, and  
19 that's the other one that I've read.

20 Q. Were you provided any other materials that  
21 are not cited in your materials considered list?

22 MR. BURNETT: Objection.

23 A. They were -- no, they were not -- what was  
24 in my materials considered was the materials that

1       were considered for the -- for the preparation of  
2       my report. There's been no relation -- they bore  
3       no value in terms of the preparation of my report.

4           Q.     And are there any other expert reports or  
5       depositions that plaintiffs' counsel provided to  
6       you in connection with this case?

7           A.     Oh, yes, there was one double-barrelled  
8       Tierney name. I can't remember the last -- Ra --  
9       Terry -- Tierney.

10          Q.     Catherine Rahilly-Tierney.

11          A.     Yeah, that's the one, yes.

12          Q.     Doctor Rahilly-Tierney is an epidemiologist  
13       retained by the defendants in this case, correct?

14          A.     Correct.

15          Q.     And you were -- plaintiffs provided you  
16       with a copy of her expert report?

17          A.     Yes.

18          Q.     Did you review that expert report?

19          A.     I read it over, yes.

20                   MS. WU: Counsel, we request that you  
21       provide a list of -- a supplemental list of  
22       materials considered.

23                   MR. BURNETT: Noting the request.

24                   MS. WU: We'll leave the deposition

1 open in case we need to ask further questions  
2 related to those materials which were not provided  
3 in advance of today's deposition.

4 MR. BURNETT: Well, Counsel, as the  
5 witness said, he did not rely on these materials in  
6 preparing his report, and he also said they weren't  
7 relevant to preparation of the report.

8 THE DEPONENT: They were given to me  
9 as background because they referred to the data  
10 that I had used in my report. They were not at all  
11 used in the preparation of my report or in my  
12 opinions since then.

13 Q. Understood, Doctor. Doctor, will you agree  
14 that the vast majority of prescription opioids --  
15 prescriptions for opioids are written in good  
16 faith?

17 MR. BURNETT: Objection. Beyond the  
18 scope.

19 THE DEPONENT: Exactly.

20 A. I don't really have an opinion -- it's not  
21 something that I've studied and was not contained  
22 in my report.

23 Q. Do you know who Mr. Joseph Rannazzisi is?

24 A. No, I do not.

1 Q. Doctor, in 2017, three-quarters of overdose  
2 deaths in Cabell County were related to illicit  
3 fentanyl, correct?

4 A. I'd have to go back and check, but that's  
5 probably -- they included fentanyl as part of the  
6 -- the spectrum of drugs found.

7 MR. BURNETT: If you need to check  
8 your report, please do so.

9 A. So what years are you talking about?

10 Q. I'm talking about 2017. But perhaps we can  
11 make this a little easier. Doctor, I'd like to ask  
12 you to -- you can pull up Exhibit 13, which will be  
13 in a separate envelope. And it's your publication,  
14 "Fentanyl and fentanyl-analog involvement in  
15 drug-related deaths."

16 A. I found it. 13, yes.

17 SMITH DEPOSITION EXHIBIT NO. 13

18 ("Fentanyl and fentanyl-analog  
19 involvement in drug-related deaths" by  
20 Smith, et al. dated 3-1-19 was marked  
21 for identification purposes as Smith  
22 Deposition Exhibit No. 13.)

23 A. 13. Yes, I have it in front of me.

24 Q. Do you recognize this document, Exhibit 13?

1 A. Yes, I do.

2 Q. What is it?

3 A. It's a article of mine, that I was involved  
4 with, published in the Alcohol and Drug Dependence,  
5 2019.

6 Q. Based on this publication and the work you  
7 did in connection with it, will you agree that for  
8 the 75 percent of overdose deaths that occurred in  
9 Cabell County in 2017, almost all of those deaths  
10 were related to fentanyl that was illicit and  
11 obtained without a prescription?

12 A. That's beyond the scope of the article. I  
13 don't have -- this article, in particular, did not  
14 look at any specific county. It looked at the  
15 state as a whole.

16 Q. Based on your work for the state as a  
17 whole, would it -- would it -- would you agree that  
18 there's been a decline in the number of fatal  
19 overdose incidents that involve any form of  
20 prescription fentanyl?

21 MR. BURNETT: Objection.

22 A. We did not examine prescription -- we never  
23 examined with this whether there was prescription  
24 fentanyl involved, but based on the proportion and

1 the CDC reports and the DEA reports, the vast bulk  
2 of the fentanyl in recent years was illicit.

3 Q. Doctor, I'd like to ask you to look to page  
4 6 of Exhibit 13.

5 MR. BURNETT: What was that, page 6?

6 THE DEPONENT: Page 6, yes.

7 MS. WU: Page 6.

8 Q. Doctor, you co-authored the article which  
9 we're looking at as Exhibit 13, correct?

10 A. Correct.

11 Q. At the top of page 6, the last sentence of  
12 the paragraph that carries over from page 5 reads  
13 "Most notable was the recent decline in the  
14 percentage of decedents who had a prescription  
15 identified fentanyl." Do you see that?

16 A. Yes.

17 Q. Is that accurate?

18 A. That was part of the finding, yes. Yes.

19 Q. Do you have any explanation for the  
20 decrease in overdoses associated with prescription  
21 fentanyl which is reported in your 2019 paper?

22 A. Yeah, I think the primary reason is the  
23 vast surge of illicit fentanyl that was brought  
24 into the country -- brought in which is very well



1 documented in DEA and CDC and other reports, and  
2 that's what's responsible for the much higher  
3 proportion of them.

4 For example, even if the number of  
5 people with a prescription remained the same in  
6 both overdoses, if you brought in a much larger --  
7 a huge increase of fentanyl deaths from illicit  
8 fentanyl, that's what you would expect.

9 Q. This shift in abuse patterns reported in  
10 your 2019 paper is driven by illicit drug cartels,  
11 correct?

12 MR. BURNETT: Objection.

13 A. I have no evidence to say that. The drugs  
14 are certainly known to be brought in by illicit  
15 drug people.

16 Q. The availability of illicit drugs drives  
17 the abuse patterns which are referenced here on  
18 page 6 of your 2019 report. Correct?

19 MR. BURNETT: Objection.

20 A. What do you mean by "driving the abuse  
21 patterns?" Certainly we're finding both  
22 prescription drugs and fentanyl in the cases up  
23 till now.

24 Q. So a short while ago, we referenced that

1 three-quarters of all overdose deaths in Cabell  
2 County for the year 2017 related to illicit  
3 fentanyl. Do you recall that?

4 A. They involved illicit fentanyl, yes. But  
5 by no means, they're the only cause. There's other  
6 drugs involved as well.

7 Q. Pharmaceutical distributors do not  
8 distribute illicit fentanyl, correct?

9 A. Correct.

10 Q. Pharmaceutical distributors also do not  
11 distribute heroin. Correct?

12 A. Correct.

13 Q. And as you've just described in explaining  
14 the abuse patterns reported in page 6 of your 2019  
15 report, market factors play a role in contributing  
16 to patterns of drug abuse. Correct?

17 A. Is that what I -- is that 6 here? Market  
18 factors? What --

19 MR. BURNETT: Yeah, if you're quoting,  
20 can you please point us to it?

21 MS. WU: I'm not. I'm referring to  
22 the doctor's earlier testimony that the  
23 availability of illicit drugs contributed to the  
24 patterns of abuse in West Virginia.

1           A.     They contributed to the deaths, certainly.  
2     The deaths are not necessarily abuse.  If illicit  
3     fentanyl came in, there could still be the  
4     underlying abuse, but then the people die at a  
5     higher rate because of the fentanyl.

6           Q.     So Doctor, the fatal overdoses which are  
7     referenced in your report do not necessarily  
8     indicate patterns of drug abuse in Cabell County,  
9     do they?

10                   MR. BURNETT:  Objection.

11           A.     They are -- you can't have a drug-related  
12     death unless there's abuse going on in the  
13     community, but if you bring in a drug like  
14     fentanyl, you can get more deaths for the same  
15     number of people that are using.

16           Q.     And you don't know what proportion of  
17     overdoses in Cabell County for the period 2001 to  
18     2018 were fatal, correct?

19           A.     No, I've made no comment on that, and I  
20     don't have any data to support anything on that.

21           Q.     Doctor, are you aware that heroin is not  
22     produced in the United States?

23           A.     I don't have any evidence one way or the  
24     other, but I had understood it that it wasn't.

1 Q. Would you agree, Doctor, that illicit drug  
2 cartels are responsible for the distribution of  
3 heroin which eventually reaches Cabell County?

4 MR. BURNETT: Objection, calls for  
5 speculation.

6 A. Yeah, it has to come in somehow. I don't  
7 know. I don't have direct evidence myself except  
8 for looking at arrests in the newspaper and those  
9 type of things.

10 Q. And that's because you haven't undertaken  
11 any analysis of the origin of drugs identified in  
12 the toxicology screens referenced in your expert  
13 report. Correct?

14 A. The origin of the drugs was not a focus of  
15 my investigation. My focus was to identify the  
16 actual individual drugs and molecules that were  
17 found in people that died.

18 Q. And the molecules involved in people who  
19 died tell you nothing about what caused that person  
20 to overdose. They just --

21 MR. BURNETT: Objection.

22 Q. -- tell you the molecules that are present  
23 in the body.

24 A. What you get in the data that we're

1 presenting is you get drugs that were considered to  
2 have contributed to the death and the multiple  
3 drugs that were considered to have contributed to  
4 the death based on what the medical examiner found,  
5 the toxicology report that may have consider -- had  
6 other drugs.

7 But then based on their expert  
8 opinion, they determined which of the drugs was  
9 considered to be part of or contributing.

10 Q. And the origin of those drugs is not part  
11 of the analysis that you've conducted for this  
12 case, correct?

13 MR. BURNETT: Objection, asked and  
14 answered.

15 A. That's correct.

16 Q. Okay. So Doctor, I'd like to ask you to  
17 pull out another document, which is Exhibit 5,  
18 which is a copy of your CV. Do you have that in  
19 front of you, Doctor?

20 A. Yes, I do.

21 MR. BURNETT: Yeah, you opened that  
22 earlier.

23 SMITH DEPOSITION EXHIBIT NO. 5

24 (Curriculum Vitae of Gordon Smith,

1 M.B., CH.B. (MD Equivalent Otago  
2 University), MPH, Appendix A to Expert  
3 Report was marked for identification  
4 purposes as Smith Deposition Exhibit  
5 No. 5.)

6 MS. WU: That's right, we did before a  
7 break. Thank you, Counsel.

8 Q. So I'm quickly going to review some of your  
9 professional history, and we'll use the CV as  
10 reference, and feel free to reference it as we walk  
11 through this.

12 MR. BURNETT: Actually --

13 Q. Doctor, have you --

14 MR. BURNETT: Sorry. Before we get  
15 into this, we've been going about an hour. We  
16 don't have to break now, but, you know, this is one  
17 place we could break --

18 MS. WU: That's fine. Before we dive  
19 in, why don't take ten minutes, if that's okay with  
20 you.

21 MR. BURNETT: Sure.

22 VIDEO OPERATOR: Going off the record.  
23 The time is 3:44 p.m.

24 (A recess was taken after which the

1 proceedings continued as follows:)

2 VIDEO OPERATOR: Now begins Media Unit  
3 7 in the deposition of Gordon Smith. We're back on  
4 the record. The time is 4:01 p.m.

5 BY MS. WU:

6 Q. Doctor, we just took a break. You  
7 understand that you're still under oath, correct?

8 A. Yes, correct.

9 Q. Okay. Doctor, do you have in front of you  
10 Exhibit 5, a copy of your CV?

11 A. Yes, I do.

12 Q. And as I said just before the break, we're  
13 going to walk through some of your professional  
14 background, and we can use your CV for reference as  
15 we go through this exercise. Feel free to look at  
16 it as we review your history.

17 Doctor, you reviewed -- you received  
18 an MB, ChB from the University of Otago Medical  
19 School in 1975; is that correct?

20 A. That's correct.

21 Q. That's equivalent of an M.D. in the United  
22 States, correct?

23 A. Correct.

24 Q. You received a master's in public health

1 from Harvard in 1981?

2 A. Yes.

3 Q. From 1975 to 1977, you were a medical  
4 intern in New Zealand?

5 A. Yes.

6 Q. In 1977, you worked at the Children's  
7 Hospital in Brisbane, Australia, correct?

8 A. Correct.

9 Q. From 1975 through 1978, you also served as  
10 a medical officer in the Cook Islands and in Papua,  
11 New Guinea, correct?

12 A. That's correct. .

13 Q. From 1978 to 1980, you supervised  
14 epidemiological research for the World Bank in  
15 Papua, New Guinea, correct?

16 A. That's correct, yes.

17 Q. You then attended Harvard, correct?

18 A. Right.

19 Q. After graduating from Harvard, you held a  
20 research fellowship at Brigham Women's Hospital in  
21 Boston, correct?

22 A. Correct.

23 Q. From 1982 until 1984, you worked as a  
24 preventive medicine resident, correct?



1 A. Yes.

2 Q. Could you briefly tell us what your  
3 responsibilities were during that period?

4 A. Which period of time is this?

5 Q. At 1982 to 1984 when you worked as a  
6 preventive medicine resident.

7 A. Oh, okay, yes. So I started off -- this  
8 was working for the Centers for Disease Control,  
9 and they have a two-year field epidemiology  
10 training program called the Epidemic Intelligence  
11 Service, and with that, I was assigned to the State  
12 Health Department in Colorado for two years where I  
13 did general field epidemiology, investigations,  
14 food-borne outbreaks, diarrheal diseases, and then  
15 also studied some injuries and death certificate  
16 data for ski injuries, which got me interested in  
17 looking at the whole mortality data which later  
18 became a big focus of mine -- my work after that.

19 And so I did that for about a year and  
20 three-quarters, and then I got asked to take a --  
21 take a -- to come and work at the Centers for  
22 Disease Control to help them develop a injury  
23 section of a big report -- because at the time, the  
24 Centers for Disease Control did not have a

1 full-time injury epidemiologist on a report for the  
2 Carter Center the CDC was doing, and I was doing  
3 general epidemiologic investigations of injuries,  
4 and we include poisonings under injuries, under the  
5 broad category of injury.

6 And then I -- I then was working in  
7 the injury group as one of the first -- their first  
8 full-time injury epidemiologist, and that's what I  
9 did my preventive medicine residency on. And also  
10 during that time, I spent three months in Nigeria  
11 working on getting (Zoom audio glitch) disease for  
12 the UNICEF on assignment.

13 Q. Thank you, Doctor. From 1985 through  
14 present, you've been affiliated with Johns Hopkins,  
15 correct?

16 A. Not all the time. From '85 to 2002, I was  
17 -- I've had affiliations with them, and I've been  
18 on advisory boards and things like that with them.  
19 But I left Johns Hopkins and then went to -- if you  
20 look at my employment history, to the Liberty  
21 Mutual Research Institute, and then went to the  
22 University of Maryland, and then was offered this  
23 endowed chair here at West Virginia.

24 Q. So you just referenced your kind of

1 academic posts, correct?

2 A. Yes.

3 Q. From 2006 -- '07 until 2016, you were  
4 professor of epidemiology and public health at the  
5 University of Maryland, correct?

6 A. Correct, yes. That's right.

7 Q. And then from 2016 through present, you've  
8 been a professor at West Virginia University,  
9 correct?

10 A. That's correct, yes.

11 Q. And you're a professor in the School of  
12 Public Health, correct?

13 A. That's correct, yes.

14 Q. You also serve as an adjunct professor of  
15 medicine, correct?

16 A. That's correct. Emergency medicine.

17 Q. Do you hold those -- both those posts  
18 today?

19 A. Yes, I do.

20 Q. At -- Doctor, you are employed by West  
21 Virginia University, correct?

22 A. That's correct.

23 Q. West Virginia University is a public  
24 institution, correct?

1 A. Yes.

2 Q. So you're an employee of the state of West  
3 Virginia?

4 A. Yes.

5 Q. Doctor, could you briefly describe the  
6 areas in which you consider yourself to be an  
7 expert?

8 A. I consider myself to be an expert in the  
9 area of injury statistics, injury data -- under  
10 injury, I would include poisoning. I've looked at  
11 a variety of the classifications -- the way we code  
12 injuries, the way we collect them in Vital  
13 Statistics.

14 I was a member of the WHO commission  
15 that designed the external cause codes, which  
16 include the poisoning codes, for the current  
17 revision of the International Disease  
18 Classification Code, which is what we use to be  
19 able to understand and code the statistics  
20 currently at the moment. We're using the 10th  
21 revision.

22 So this whole use of health data for  
23 research and to understand health problems. I have  
24 analyzed hospital data with regard to a variety of

1 injuries, from alcohol-related injuries, to motor  
2 vehicle crashes.

3 And then in more recent years, I -- my  
4 expertise has been looking at trauma and alcohol  
5 and trauma and then substance abuse and trauma and  
6 the role of drugs and trauma and because of that  
7 work and because of my expertise in this whole area  
8 of injury - which would include the poisoning under  
9 - and the ability to analyze the kind of medical  
10 examiner data, I've been working with the medical  
11 examiner data in Maryland, and I expect I was the  
12 first person to computerize the medical examiner  
13 data in Maryland.

14 When I first started there, we were  
15 studying drownings, and we had to look just at code  
16 books, and we developed the first computer system  
17 there, data system.

18 So I've been looking at substance  
19 abuse relationship to injuries a lot -- for most of  
20 my career, and then most recently being in West  
21 Virginia, I've particularly concentrated just on  
22 the poisoning aspect of it because the drug  
23 overdose problem is so great, you can't not look at  
24 that when you come to West Virginia.

1 Q. And Doctor, you've published over 200 peer  
2 reviewed articles over the course of your career,  
3 correct?

4 A. Correct.

5 Q. Of those 200 art -- plus articles, can you  
6 identify the articles you published that are  
7 specific to opioids?

8 A. The specific, as I mentioned, I've been  
9 working in the area of substance abuse, and the --  
10 that general area. Let me just look over --

11 Oh, good, you have -- so you do have  
12 my most recent one that includes --

13 Okay, my -- this is on page 28. No.  
14 207, the "Quantifying enhanced risk from alcohol  
15 and other factors in polysubstance-related deaths."  
16 So I don't have to add that. That is on there,  
17 good.

18 No. 202, looking at nonfatal overdoses  
19 in emergency room -- emergency department --  
20 Emergency Medical Services data.

21 The others mostly all related to  
22 alcohol. No. 2000 {sic}, which is the "Fentanyl  
23 and fentanyl-analog" "and drug-related abuse."

24 And the bulk of my other ones have all

1     been related to alcohol and substance abuse and  
2     generally in the area of injuries.

3             But particularly a lot of them would  
4     involve using data and the whole coding and how we  
5     track diseases, including tracking opioid poisoning  
6     and being able to work on that.

7             And I've been part of an international  
8     group of injury statistics that analyzes problems  
9     and injury statistics, including poisoning deaths.

10            Q.     Thank you, Doctor.   So Publication No. 200  
11     is the 2019 fentanyl study which we discussed  
12     earlier today, correct?

13            A.     That's correct, yes.

14            Q.     And that is one of the two opioid-specific  
15     publications that you just referenced.   Correct?

16            A.     One of three.   Because the 2002 {sic},  
17     which is opioid overdose -- overdoses from the EMS  
18     run data, and the other one is 2007 {sic},  
19     "Quantifying" "risk from alcohol and other factors  
20     in" polysubstance deaths."

21                   And there's also a number of other  
22     publications that are working on submitting for  
23     publication that we've been working on.

24                   But they -- it always takes time when

1     you move from one university to the other to get  
2     things published.

3           Q.     Doctor, Article 207 relates to alcohol and  
4     polysubstance related deaths.    Correct?

5           A.     Yes, that's drug deaths, yes.

6           Q.     It's not limited to opioid-related deaths,  
7     correct?

8           A.     But it's looking at, in particular, how --  
9     and the vast bulk of the drugs that we examine are  
10    opioids, and we find out, for example, that the --  
11    if alcohol -- look at the alcohol involvement in  
12    these polysubstances are part of the general drug  
13    deaths.

14          Q.     So you first published a peer reviewed  
15    article related specifically to opioids in 2019,  
16    correct?

17                   MR. BURNETT:   Objection.

18          A.     With particularly to opioids.    But I think  
19    I would emphasize that my expertise has been more  
20    on how we classify causes of death and how medical  
21    examiner data is used, and so it's a natural jump  
22    to include opioids.

23          Q.     But in terms of your publications, the  
24    first one specific to opioids was in 2019, correct?



1 A. That's probably correct.

2 Q. Doctor, you also have a number of grants  
3 listed in your CV. Just to try to short-circuit  
4 this review, am I correct that the first grant you  
5 received which is specifically related to opioids  
6 began in 2017?

7 A. Yeah, that was the one we wrote when I  
8 first came to West Virginia, yes.

9 Q. Are there any grants that you received  
10 prior to 2017 that specifically relates to opioids?

11 A. There's a grant we're working on now with  
12 one of my doctoral students, and she did her  
13 analysis -- published the -- she's published her  
14 thesis on it, is related to the drug toxicology  
15 from the -- from the center data and looking at the  
16 risk of people dying -- was included in it alcohol  
17 and other drugs.

18 And we specifically are looking at --  
19 and she's done all the analysis and published and  
20 successfully defended her thesis, but we're still  
21 working on drafts of the papers to get those out  
22 looking at the drugs and the role of drugs in  
23 trauma-related deaths.

24 Q. You didn't receive any grant money specific

1 to opioid research prior to your arrival in West  
2 Virginia, correct?

3 A. It wasn't specific. It was related to  
4 alcohol and drugs prior to coming to West Virginia,  
5 one of the drugs.

6 Q. Doctor, and now I just want to turn quickly  
7 to your personal background. Have you ever been  
8 convicted of a crime?

9 A. No, I haven't.

10 Q. Have you ever been arrested?

11 A. Nope.

12 Q. Have you ever been disciplined by your  
13 employer?

14 A. No.

15 Q. Have you ever been disciplined by a  
16 professional board, such as the medical board?

17 A. No, I haven't.

18 Q. Have you ever personally used illegal  
19 drugs?

20 A. No, I haven't.

21 Q. Do you currently use prescription opioids?

22 A. No, I do not.

23 MR. BURNETT: Counsel, I'm going to  
24 interject here. What is the relevance of this line

1 of questions - they're highly personal - about his  
2 personal life?

3 MS. WU: Goes to bias.

4 MR. BURNETT: I find the questions  
5 problematic. I haven't heard any other expert  
6 being asked these sorts of questions. I don't know  
7 if you have any reason to think his answer would be  
8 affirmative to any of these.

9 MS. WU: These are questions that  
10 plaintiffs have asked defense testifying witnesses,  
11 and we simply seek symmetry in this proceeding,  
12 Counsel.

13 MR. BURNETT: Again, that's not one  
14 way or the other, but --

15 MS. WU: That's fine.

16 Q. Doctor, have you ever used prescription  
17 opioids?

18 A. I presume so. I fractured my femur when I  
19 was about 19 years old, and so I presumably was  
20 given -- I certainly hope I was given some opioids  
21 when I fractured my femur, run over by a car.

22 And then I also had a ski injury and  
23 fractured my tibia -- fibula when I was at  
24 university.

1                   So high school and -- I think I  
2                   probably got one dose of opioids when they were  
3                   bringing me down the mountain on a stretcher and  
4                   then put in the ambulance and taken to the  
5                   hospital.

6           Q.     Thank you, Doctor. Following those  
7                   incidents of prescription for opioid-class  
8                   medications, did you struggle with addiction?

9           A.     No, I did not. They were very short  
10                  courses.

11          Q.     Doctor, earlier today - just before our  
12                  last break - you testified that prescription pills  
13                  came into Cabell County somehow. And I just want  
14                  to return to that statement. You're aware that  
15                  prescription pills were trafficked by drug  
16                  trafficking organizations into Cabell County,  
17                  correct?

18                         MR. BURNETT: Objection.

19          A.     I -- yes, I said that they -- that they are  
20                  -- that some are, yes.

21          Q.     Doctor, are you also aware that law  
22                  enforcement in Cabell County has testified that a  
23                  substantial portion of opioids abused in Cabell  
24                  County -- prescription opioids abused in Cabell

1 County were trafficked by drug trafficking  
2 organizations?

3 MR. BURNETT: Objection.

4 A. Not particularly. I don't know what  
5 proportion. There were an awful lot of opiates  
6 prescribed --

7 Q. Doctor --

8 A. -- as well.

9 Q. Doctor, are you aware that Cabell County  
10 and the City of Huntington are often referred to as  
11 "Little Detroit"?

12 MR. BURNETT: Objection.

13 A. Actually, I haven't heard that term.  
14 That's interesting.

15 Q. I thought you might have read it in the  
16 HIDTA reports you referenced earlier.

17 A. Yeah, I probably have.

18 Q. I'd recommend them to you.

19 MS. WU: Thank you, Doctor. I  
20 appreciate your time today. I have no further  
21 questions.

22 Pass the witness.

23 THE DEPONENT: Okay.

24 MR. BURNETT: Do counsel for the other

1 defendants have any questions?

2 MS. VITALE: No questions at this  
3 time. Thank you.

4 MR. BURNETT: So that was two -- I  
5 can't remember which -- who the third defendant is,  
6 but not hearing any other --

7 I may have a few questions for  
8 redirect, so if we could take a break, say, until  
9 4:30. If I do, it will be short.

10 MR. FRANKS: This is -- this is Ray  
11 Franks, local counsel for Cardinal. I defer to  
12 Danielle, who's national counsel, as to whether she  
13 has any questions for Cardinal.

14 MS. SOCHACZEWSKI: No questions here.  
15 Thank you.

16 MR. BURNETT: I didn't hear the male  
17 voice before that.

18 MR. FRANKS: Well, it's moot now.  
19 This is Ray Franks, I'm local counsel for Cardinal.  
20 I was going to defer to Danielle as to whether  
21 Cardinal had any questions for the witness, but she  
22 piped up right after that and said that they don't.

23 MR. BURNETT: All right. So it sounds  
24 like none of the defendants have any further

1 questions. Let's come back in about ten minutes  
2 for a possible redirect.

3 VIDEO OPERATOR: Going off the record,  
4 the time is 4:20 p.m.

5 (A recess was taken after which the  
6 proceedings continued as follows:)

7 VIDEO OPERATOR: Now begins Media Unit  
8 8 in the deposition of Gordon Smith. We're back on  
9 the record. The time is 4:34 p.m.

10 EXAMINATION

11 BY MR. BURNETT:

12 Q. Good afternoon, Doctor Smith.

13 A. Good afternoon.

14 Q. In your professional work, it is common for  
15 you to rely on other sources as the basis for your  
16 opinions; is that right?

17 A. Very common. In fact, much of the research  
18 that's done relies on different data sources from  
19 different origins, particular studies.

20 Q. And in this case, among other sources of  
21 data, you've relied on Vital Statistics data that  
22 came from the West Virginia Medical Examiner's  
23 Office; is that right?

24 A. That's correct.

1 Q. And you have relied on that Vital  
2 Statistics data in the past in your academic and  
3 other professional work, right?

4 A. In both I have, and it's widely used in  
5 research -- the Vital Statistics data, either  
6 specific state studies or national data or  
7 comparing data from one country -- state to the  
8 next, widely used in both academic publications and  
9 peer-reviewed journals.

10 The Centers for Disease Control use it  
11 very widely to decide disease priorities, and the  
12 state uses it in West Virginia to look and  
13 understand the problems and where their risky areas  
14 are.

15 Q. And you use that Vital Statistics data in  
16 prior publications in academic journals, right?

17 A. Exactly. And that's been one of my area of  
18 expertise, is this whole coding and the  
19 International Disease Classification Codes, which  
20 is the way that we analyze the data.

21 Q. And you consider that Vital Statistics data  
22 to be reliable?

23 A. I would consider it to be very reliable.  
24 It's particularly reliable in a numb -- in limited



1 number of states that have a good medical examiner  
2 system, and the published articles stating that  
3 West Virginia is a group of five or six or seven  
4 states with the best quality drug overdose data in  
5 the country.

6 Q. And the work that you did in preparing this  
7 report for this litigation is similar to the type  
8 of work that you do in preparing academic articles,  
9 right?

10 A. Exactly, yes.

11 Q. And the data that you used for this report,  
12 you believe is the most authoritative, accurate and  
13 complete source of overdose data for Cabell County?

14 A. That's the most accurate that anybody could  
15 get.

16 Q. Okay.

17 MR. BURNETT: I have no further  
18 questions. Thank you.

19 MS. WU: Thank you, Doctor. I have no  
20 further questions for McKesson.

21 THE DEPONENT: Thank you.

22 VIDEO OPERATOR: If there are no  
23 further questions, we are off the record at  
24 4:37 p.m., and this concludes today's testimony

1 given by Gordon Smith.

2 The total number of media units used  
3 was eight and will be retained by Veritext.

4 (Having indicated he would like to  
5 read his deposition before filing,  
6 further this deponent saith not.)

7

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1 STATE OF WEST VIRGINIA,  
2 COUNTY OF JACKSON, to wit;  
3

4 I, Teresa S. Evans, a Notary Public within  
and for the County and State aforesaid, duly  
5 commissioned and qualified, do hereby certify that  
the foregoing deposition of GORDON SMITH was duly  
6 taken by me and before me at the time and place and  
for the purpose specified in the caption hereof,  
7 the said witness having been by me first duly  
sworn.

8  
9 I do further certify that the said  
deposition was correctly taken by me in shorthand  
10 notes, and that the same were accurately written  
out in full and reduced to typewriting and that the  
witness did request to read his transcript.

11  
12 I further certify that I am neither  
attorney or counsel for, nor related to or employed  
13 by, any of the parties to the action in which this  
deposition is taken, and further that I am not a  
relative or employee of any attorney or counsel  
14 employed by the parties or financially interested  
in the action and that the attached transcript  
15 meets the requirements set forth within article  
twenty-seven, chapter forty-seven of the West  
16 Virginia Code.

17 My commission expires October 25, 2020.  
Given under my hand this 25th day of October, 2020.

18  
19 <%10538,Signature%>  
Teresa S. Evans  
20 RMR, CRR, RPR, WV-CCR  
21  
22  
23  
24

Veritext Legal Solutions  
1100 Superior Ave  
Suite 1820  
Cleveland, Ohio 44114  
Phone: 216-523-1313

September 25, 2020

To: David D. Burnett

Case Name: City Of Huntington v. Amerisourcebergen Drug Corporation,  
Et Al.

Veritext Reference Number: 4241613

Witness: Gordon Smith                      Deposition Date: 9/22/2020

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown

above, or email to [production-midwest@veritext.com](mailto:production-midwest@veritext.com).

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4241613

City Of Huntington v. Amerisourcebergen Drug Corp, Et Al.

DATE OF DEPOSITION: 9/22/2020

WITNESS' NAME: Gordon Smith

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

\_\_\_\_\_

Date

\_\_\_\_\_

Gordon Smith

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;  
They signed the foregoing Sworn Statement; and  
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_

Notary Public

\_\_\_\_\_

Commission Expiration Date

DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4241613

City Of Huntington v. Amerisourcebergen Drug Corp, Et Al.

DATE OF DEPOSITION: 9/22/2020

WITNESS' NAME: Gordon Smith

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Gordon Smith

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;  
They have listed all of their corrections in the appended Errata Sheet;  
They signed the foregoing Sworn Statement; and  
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expiration Date

ASSIGNMENT NO: 4241613

PAGE/LINE(S)	CHANGE	/REASON
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Date Gordon Smith

SUBSCRIBED AND SWORN TO BEFORE ME THIS

DAY OF \_\_\_\_\_, 20\_\_\_\_.

Notary Public

Commission Expiration Date

[&amp; - 2016]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS  
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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